MEDICAL BOARD OF CALIFORNIA
Executive Office

QUARTERLY BOARD MEETING

July 25, 2008

Embassy Suites
Golden Gate Room
250 Gateway Blvd.
South San Francisco, CA 94080
(650) 589-3400

Action may be taken on any item listed on the agenda.

AGENDA

Friday, July 25, 2008 – 9:00 a.m. to 2:00 p.m.
(or until the conclusion of business)

1. Call to Order/Roll Call

2. Approval of Minutes from the April 25, 2008 Meeting

3. Public Comment on Items not on the Agenda

4. President's Report

5. Executive Director's Report – Ms. Johnston
   A. Budget Overview and Staffing Update
   B. Proposed Meeting Dates for 2009

6. Department of Consumer Affairs November 2008 Summit – Ms. Lopez

7. Recognition of International Medical School Program
   A. Medical University of Lublin (English Program) – Lublin, Poland
   B. Poznan University of Medical Sciences (English Program) – Poznan, Poland

8. Presentation on the Victims Compensation Program – Chip Skinner, Ph.D.

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

9. Revision of Effective Date of Fee Reduction Regulations – Ms. Kirchmeyer

10. Legislation – Ms. Whitney
    A. 2008 Legislation
    B. Status of Regulatory Action

11. Discussion of SB 376 Report to the Legislature (District Hospital Employment of Physicians Pilot Program) – Ms. Whitney & Mr. Schunke

12. Enforcement Chief's Report – Ms. Threadgill
    A. Approval of Orders Restoring License Following Satisfactory Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation
    B. Enforcement Program Update
    C. Expert Reviewer Survey Update

13. Vertical Enforcement Update – Ms. Threadgill & Mr. Ramirez
    A. Vertical Enforcement Statistics
    B. Recommendation to Improve Disciplinary Process Timelines

14. Licensing Chief's Report – Ms. Pellegrini
    A. Licensing Program Update
    B. Special Programs Update
    C. Midwifery Advisory Council Report

15. Special Faculty Permit Review Committee Appointment – Ms. Pellegrini

16. California Physician Corps Program Update – Ms. Yaroslavsky

17. Education Committee Update – Ms. Yaroslavsky

18. Medical Errors Task Force Update – Mr. Zerunyan

19. Physician Assistant Committee Update – Dr. Low

20. Wellness Committee Update – Dr. Duruisseau

21. Agenda Items for November 2008 Meeting

22. Adjournment

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Teresa Schaeffer at (916) 263-2389 or sending a written request to Ms. Schaeffer at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Requests for further information should be directed to the same address and telephone number.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

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For additional information call (916) 263-2389.

MEDICAL BOARD OF CALIFORNIA

Executive Office

Agenda Item 2

Sacramento Convention Center
1400 J Street, Room 204
Sacramento, CA

April 25, 2008

MINUTES

Agenda Item 2 Call to Order/Roll Call

Dr. Fantozzi called the meeting of the Medical Board of California (Board) to order on April 25, 2008 at 9:00 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Richard Fantozzi, M.D., President
Steve Alexander
Cesar Aristeiguieta, M.D.
Hedy Chang
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

Members Absent: None

Staff Present:

Barbara Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Stacie Berumen, Manager, Licensing Program
Fayne Boyd, Manager, Licensing Program
Kathi Burns, Manager, Licensing Program
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Kurt Heppler, Staff Counsel, DCA Legal Office
Armando Melendez, Business Services Office
Kelly Nelson, Legislative Analyst

Regina Rao, Business Services
Paulette Romero, Associate Analyst
Teresa Schaeffer, Executive Assistant
Kevin Schunke, Regulation Coordinator
Anita Scuri, Senior Staff Counsel, DCA Legal Office
Renee Threadgill, Chief of Enforcement
Lori Taul, Office Technician
Frank Valine, Diversion Program Administrator
Linda K. Whitney, Chief of Legislation

Members of the Audience:

Mark Baker, South Coast Med Spa
Marla Bettencourt, Medi Spa Radience
Carl Brakensiek, California Society of Industrial Medicine & Surgery
John Caldwell, Cal Derm
Steve Cattolica, California Society of Physical Medicine and Rehab
Kathleen Creason, Osteopathic Physicians & Surgeons of California
Frank Cuny, Executive Director, California Citizens for Health Freedom
Norman Davis, California Med Spa Management Association
Carrie Elder, R.N., General Public
Francine Farrell, MS, MFT, Pacific Assistance Group
Julie D'Angelo Fellmeth, Center for Public Interest Law
Chris Finn, Skin Medix
Sherellen Gerhart, MD, Self and Dignity Medical
Faith Gibson, Midwifery Advisory Council
Mark Goldstein, Respiratory Care Board
Beth Grivett, California Academy of Physician Assistants
David Groza, Respiratory Care Board
Dennis Harper, American Laser Center
Lori Haney, Celibre Medical
Cyndi Howard, R.N., American Laser Centers
Christian Jagusch, South Coast Med Spa
Ron Joseph, California Endowment
Cindy Kanemoto, Department of Consumer Affairs
Suzanne Kilmer, MD, Laser & Skin Surgery Center of No. California
Dr. Will Kirby, General Public
Tara Kittle, Healthcare Consumer
Clete Kushida, MD, California Sleep Society
Erin Levy, Pure Med
Pamela Linney, R.N., General Public
Missey McCallum, R.N., Dignity Medical Aesthetics
Brett Michelin, California Medical Association
Tina Minasian, General Public
Stephen Moore, General Public
Anne Moreland, RN, Bay Area Body Enhancement Clinic

Stephanie Nunez, Respiratory Care Board
Michele Panora, Vitality Medical Laser Clinic
Rosielyn Pulmano, Senate B & P Committee
Carlos Ramirez, Senior Assistant Attorney General
Celia Remy, MD, Vitality Medical Laser Clinic
Damon Scuzzo, South Coast Med Spa
Tim Simerson, M.D., General Public
Carrie Sparrevohn, L.M., California Association of Midwives
John Valencia, Wilke, Fleury, Hoffelt, Gould & Birney, LLP
Alan Voss, General Public
Spencer Walker, Department of Consumer Affairs
Jamie Warner, Belle Visage Medical Coop
Brian Warren, Department of Consumer Affairs
Hermine Warren, APRN, Association of Medical Esthetic Nurses
Angelo Whitfield, Sophus Consulting
Anthony Williams, California Medical Association

Agenda Item 3 Approval of Minutes from January 31 - February 1, 2008 Meeting

It was m/Yaroslavsky, s/Moran, c/All to approve the minutes from the January 31 – February 1, 2008 meeting.

In order to remain consistent with the record, the agenda items presented in these minutes are listed in the order discussed at the April 25, 2008 meeting.

Agenda Item 4 Public Comment on Items not on the Agenda

Ron Joseph provided information to the Board on a study being funded by a grant from The California Endowment entitled "Strengthening the Community's Voice" on California's Health Care Licensing Boards. He explained the project aims to promote closer ties between health care licensing board public members and culturally diverse grassroots constituencies so as to increase the attention paid to cultural and linguistic competence in board policy deliberations and enhance the boards' understanding of the many ways the board's decision-making affects Californians' access to safe, appropriate care. Mr. Joseph promised to return and inform the Board of their progress at a future meeting.

Agenda Item 5 REGULATIONS – PUBLIC HEARING

Dr. Richard Fantozzi called the hearing to order and announced the Board would conduct a public hearing on the proposed regulations to amend Sections 1351.5 and 1352 of Title 16 of the California Code and Regulations to reduce license and renewal fees by $22 to offset costs from the elimination of the Diversion Program. For the record, Dr. Fantozzi established the date and time of the hearing as April 25, 2008 at 9:07 a.m. He briefly described the regulatory proposal

and gave instructions to potential speakers. He described the six legal review standards with which regulations must comply as well as the procedure that would be followed during the hearing.

A. Reduction in Initial License Fee and Renewal Fee to Offset Elimination of Diversion Program – Business and Professions (B&P) Code Sections 2340 et seq., which authorizes the Board's Diversion Program, become inoperative July 1, 2008. Section 2435.2 of the B&P Code states that the Board shall reduce license and renewal fees if the Diversion Program is eliminated. Therefore, pursuant to the requirements of the latter section, the board is proposing to amend sections 1351.5 and 1352 to reduce the initial license fee and biennial renewal fee from $805 to $783.

Anita Scuri, Senior Legal Counsel explained this proposal would make conforming changes to reflect statutory changes and to reflect elimination of the Diversion Program.

Public testimony was heard from Anthony Williams, California Medical Association (CMA). He stated there should be some type of replacement program available to physicians to treat substance abuse and mental illness issues and the Board could redirect the reduction of the license and renewal fees to such a program through legislation.

Mr. Williams asked why only $1.2 million had been identified to be returned to physicians when in Fiscal Year (FY) 2006/2007 the Diversion Program budget was $1.68 million and in FY 2007/2008 the budget was $1.4 million.

Kim Kirchmeyer, Deputy Director, responded and directed the members' attention to page 146 in their Board packet. Ms. Kirchmeyer stated the FY 2006/2007 budget of $1.7 million included the $300,000 study conducted by the Bureau of State Audits (BSA) and the one time costs for cars and equipment for new positions. She added the $1.2 million figure came from the DCA Budget Office and it does not include pro rata.

A motion was made and seconded to adopt the regulation to amend 1351.5 and 1352 of Title 16 to reduce the initial license fee and renewal fee. The motion carried.

B. Disciplinary Guidelines

Dr. Richard Fantozzi called the hearing to order and announced the Board would conduct a public hearing on the proposed regulation to amend Sections 1361 in Article 4 of Chapter 2, Division 13, Title 16 of the California Code of Regulations. For the record, Dr. Fantozzi established the date and time of the hearing as April 25, 2008 at 9:40 a.m. He explained this proposal would amend our regulations which incorporate by reference the disciplinary guidelines entitled "Manual of Disciplinary Guidelines and Disciplinary Orders." These amendments are being made to keep the guidelines current and useful. First, references to the Division of Medical Quality are amended to refer to the Board. Second, conforming changes are being made to reflect the elimination of the Diversion Program.

Anita Scuri, Senior Legal Counsel, clarified the proposed amendments to the existing regulatory language.

No oral testimony was submitted. No written testimony was submitted within the comment period.

After calling for comments from the members and receiving none, Dr. Fantozzi then called for a motion.

A motion was made and seconded to adopt the amendments to the Section 1361 of the CCR. The motion carried unanimously.

Agenda Item 6 Petition to Promulgate Regulations Pursuant to Government Code Section 11340.6 Concerning Physician Direct Supervision

Kurt Heppler, Staff Legal Counsel, DCA, explained the Board received a petition from John Valencia on behalf of the American Society for Dermatologic Surgery Association, the CalDerm and the Osteopathic Physician and Surgeons of California to consider amending its regulations to define the supervision of nurses. Mr. Heppler advised the Board they could accept or deny the petition in whole or in part.

Ms. Scuri clarified this is not a hearing; this is the time to make a decision on the petition.

A motion was made and seconded to adopt staff's recommendation to deny the petition at this time, pending the outcome of AB 2398 and SB 1454.

Public Comment was heard by:

- John Valencia, Wilke, Fleury, Hoffelt, Gould & Birney, LLP, spoke in support of accepting the petition.
- Suzanne Kilmer, MD, Laser & Skin Surgery Center of Northern California, spoke in support of the petition.
- John Caldwell, Cal Derm, spoke in support of the petition.
- Anthony Williams, CMA spoke in support of the petition.

Discussion ensued by the members.

Dr. Aristeiguieta stated the Board could move forward in the event the legislation is unsuccessful.

Ms. Schipske stated the main question now is how to define direct supervision.

Dr. Moran stated her concern is this petition might not be the appropriate vehicle.

Dr. Fantozzi called for the motion. The motion carried. (Vote: 12-1, 1 abstained)

Agenda Item 10 Cultural and Linguistic Physician Competency Workgroup Meeting Update

Ms. Chang reported the initial grant provided by the California Endowment to the Institute of Medical Quality (IMQ) for incorporation of cultural and linguistic competency components into all continuing medical education (CME) courses may be extended. So far, the grant has enabled IMQ to assist continuing medical education providers to incorporate necessary requirements into CME courses and serve as a resource to physicians to locate particular course topics through the establishment of an informational Web site and by holding various workshops and seminars. A meeting of the Workgroup members will be scheduled for July or August of 2008 to study the progress of cultural and linguistic competency opportunities for California physicians.

Agenda Item 7 President's Report

Dr. Fantozzi reported on the following events:

- He attended a special hearing in March 2008 and provided testimony for Senator Mark Ridley-Thomas on the review of physicians and health practitioner's substance abuse programs.
- He and Barb Johnston will be attending the Federation of State Medical Boards' (FSMB) Annual meeting being held on May 1-3, 2008 in San Antonio, Texas. He announced Hedy Chang is a candidate for an elected position on the Nominating Committee of the FSMB and wished her success.
- During the past few months he has been interviewed by a variety of newspapers and CNN regarding the end of the Diversion Program

Dr. Fantozzi stated the Wellness Committee is making great progress. They are working on developing a Web site which will be available soon. He thanked Dr. Duruisseau for the progress of the committee.

Agenda Item 8 Executive Director's Report

A. Budget Overview and Staffing Update

Ms. Johnston directed the members' attention to page 147 of their board packet for information on the budget. She noted concept papers were submitted in April and the final Budget Change Proposal's (BCP's) will be submitted to the Department by June 1, 2008. The board will know by October/November if the BCP's will be approved.

Ms. Johnston announced she was pleased to report the monumental task of moving into the Board's new headquarters location is completed. She reported one of the main challenges

related to this massive undertaking was the difficulties encountered with the new telephone system, FAX machines, card keys and conferencing call capabilities. She expressed concern the Board may receive complaints from consumers even though notice was provided on our Web site regarding the relocation.

Ms. Johnston reported Kathi Burns has been acting as Interim Chief of Licensing. She stated Ms. Burns has done an outstanding job in providing leadership and decreasing license application timelines.

Ms. Johnston provided an update on vacancies and explained the Board continues to recruit and train investigators. She reported the Board currently has a 17% vacancy and it is anticipated that by mid-summer it will be at 31%. She explained the high vacancy rate is compounded by several planned retirements and by the continuation of staff leaving for other positions. She stated the main challenge remains compensation for Board investigators. She reported the investigator compensation study began this week and staff has been in discussion with both the Department and Agency regarding the Board's continued request to improve compensation for our investigators.

B. Update on Board Mandated Reports

Ms. Johnston provided an update on Board mandated reports:

- Study of peer review pursuant to B&P Code section 805.2 – The contracted vendor is on schedule and expects to have a draft on June 1, 2008.
- Study of medical malpractice insurance for volunteers pursuant to B&P section Code 2023 – Board staff is obtaining a contact through the Department with a vendor to perform the study.
- Study of public disclosure pursuant to B&P Code section 2026 – The study is being conducted by the California Research Bureau and they are expected to have a report by July 1, 2008.

Agenda Item 9 California Physician Corp Program Update

Barbara Yaroslavsky reported the Health Professions Education Foundation (HPEF) is pleased to have a new director in place. They are working vigorously on developing opportunities and cultivating donors to continue support for the Stephen M. Thompson Loan Repayment Program.

Agenda Item 11 Education Committee Update

Ms. Yaroslavsky provided an update on the staff's proactive outreach/communication efforts since the last Board meeting. The Board's actions regarding the Diversion Program continue to generate particular interest in the media. She stated in the last quarter, staff has represented the Board at six consumer-oriented events, four professional organization events and have more events scheduled this summer. Two recent Board Newsletter articles, "House", written by Dr.

Aristeiguieta, and the "Physician Wellness" article, written by Dr. Duruisseau, have been very well received. Ms. Yaroslavsky asked members to contact Candis Cohen if they would like to add an article in the newsletter.

Ms. Yaroslavsky reported that Peter Moskowitz, M.D., from Stanford University, provided a presentation on physician health and wellness. The committee also heard related reports from Jeff Hall, University of California, Office of the President; Dr. David Shearn, Kaiser Permanente; and Dr. Maria Savoia, U.C. San Diego.

Public comment was heard by Tara Kittle, health care consumer, who commented the causes of physician burnout needed to be explored.

Agenda Item 12 Medical Errors Task Force Update

Dr. Aristeiguieta reported the Task Force adopted the following working statement:

"To examine the Board's role in promoting patient safety through developing or participating in systems that encourage and assist physicians in addressing medical errors consistent with the Board's mission and resources."

He stated the next step is to define "Medical Errors" within the context of the Medical Board and within its mission.

Dr. Low explained the issue of no fault reporting was a tool to gather more data to define medical errors.

Ms. Schipske stated there may be a need for a no fault reporting system however the Board is not the entity to establish or utilize it.

A lengthy discussion followed by the members. In conclusion some members felt policy decisions should be based on the Board's mission which is to license, and when necessary, discipline physicians when they violate the Medical Practice Act. Members agreed the Board should not support any type of no fault, confidential medical error reporting system.

Agenda Item 13 Physician Assistant Committee

Dr. Low reported he was appointed as the Medical Board member to serve on the Physician's Assistant Committee (PAC). He provided an update on the February 2008 meeting and reported the PAC is sponsoring legislation (AB 2482) that would authorize the committee to require the licensees to complete continuing education as a condition of license renewal. He explained this bill would limit the continuing education requirements to no more than 50 hours every two years and would require the committee to except certification by a specified commission or another qualified, certifying body as evidence of compliance with continuing education requirements.

Dr. Low also provided an update on AB 3 which allows a physician assistant to administer, provide, or issue drug orders for Schedules II – V without advance approval by a supervising physician and surgeon, **if the physician's assistant completes specified education requirements.** He reported the PAC has held numerous public forums over the past 6 months on this issue and have decided to move forward with regulations to establish course, content, course time frames, define course providers, and provide a written examination. The hearing on these proposed regulations will be held on May 1, 2008 at the PAC meeting in Sacramento.

Agenda Item 14 Licensing Chief's Report

A. Renewal of Special Faculty Permits – Continuing Medical Education

Kathi Burns, Interim Chief of Licensing, reported this item was being deferred to the legislative portion of the meeting.

B. Licensing Program Update

Ms. Burns provided an update on the licensing program statistics as noted in the chart on pages 161 and 162 of the board packet.

Ms. Yaroslavsky asked Ms. Burns how these statistics compare to previous years as she had heard that nationally there was a decrease in the issuance of medical licenses.

Ms. Burns indicated that although, at this point in the fiscal year, the number of licenses issued appeared low, the number of applications received was high, indicating that a decrease in the number of licenses was not likely.

Ms. Burns reported the Licensing Section is fully staffed and processing applications within mandated time requirements.

Ms. Burns reported staff has completed the outline of an on-line application instructional program designed to assists applicants in completing the Board's application for medical licensure. Staff is seeking proposals from outside design firms to further develop the outline into a tutorial course accessible on the Internet.

C. Special Programs Update

Ms. Burns reported a Special Programs workshop was held on April 3, 2008, via video conference in Sacramento, Oakland and Los Angeles, California. Six of the eight medical schools were represented. The workshop focused on license exemptions authorized by Business and Professions Code sections 2111, 2113 and 2168. Staff provided an overview of the application process and site visit protocols during the workshop and responded to various questions from those in attendance. Further workshops will be needed during the year to discuss possible regulatory amendments to improve and clarify the intent and proper use of these special license exemptions.

D. Midwifery Advisory Council (MAC) Report

Ms. Burns reported the next MAC meeting will be held on June 19, 2008, in Sacramento. The MAC spent this past year developing the format to collect practice data related to California licensed midwives as authorized by recent law. The data information is collected by the Office of Statewide Health Planning and Development and reported to the Board each July. To date, 126 out of a possible 196 licensed midwives have submitted reports. A reminder note will be sent to those next week who have yet to report.

The MAC continues to research the possibility of having the National College of Midwifery in New Mexico, provide remedial and re-entry to practice training for California Licensed Midwives.

Carrie Sparrevohn, L.M., requested the Board allow the MAC to hold public meetings to focus on full implementation of SB 1950 and to define physician supervision to ensure public safety is appropriately protected.

Agenda Item 15 Enforcement Chief's Report

A. Enforcement Program Update

Renee Threadgill, Chief of Enforcement, reported enforcement staff conducted an outstanding post-certified, (peace officers standards and training) supervisor training. She introduced Robin Braafladt and Laura Sweet, both Senior Enforcement staff and presented Ms. Sweet with a plaque for her series of articles entitled "The Seven Deadly Sins".

She announced the Precedential Decisions have been indexed and are available on the Board's Web site.

Public comment was heard by Frank Cuny, California Citizens for Health Care Freedom. He saluted the Board for their individual struggles and dedication. He commented he would like to see physicians practice alternative medicine that is safe and effective. He recommended the Board use reviewers trained in the same field as the physician in alternative medicine cases.

Ms. Threadgill, directed the Board to the Expert Utilization Report where there are a number of complimentary alternative experts listed.

Dr. Aristeiguieta suggested the Board use a median and a mean when reporting enforcement statistics.

B. Approval of Orders Restoring License Following Successful Completion of Probation, Orders Issuing Public Letter of Reprimand and Orders for License Surrender During Probation.

It was m/Alexander, s/Aristeiguieta to approve the orders restoring license following successful completion of probation, orders issuing public letter of reprimand, and orders for license surrender during probation.

Mr. Zerunyan asked for clarification regarding reference to the term "successful completion of probation" and suggested it would be more appropriate to change the language to read: "following ***satisfactory*** completion of probation".

Ms. Threadgill explained these orders do not pertain to petitions for early termination or modification of probation. They result from restoration of licenses upon successful completion of probation.

Mr. Alexander modified his motion to reflect Mr. Zerunyan's comments to include the change to the language on the consent orders from "successful" to "satisfactory". The motion carried.

C. Expert Reviewer Survey Update

Ms. Threadgill directed the members' attention to page 163 of their board packet for the results of the Expert Survey Questionnaire. She highlighted some suggestions for improvement to the program included receiving the information in electronic format versus a hard copy. She stated enforcement staff will explore implementing this suggestion.

D. Expert Reviewer Utilization Update

Ms. Threadgill directed the members' attention to page 167 of their board packet for information on Use of Experts by Specialty and cases sent to experts for review. The information indicates we continue to increase our number of experts while not over utilizing any one expert.

E. Vertical Enforcement Statistics

Ms. Threadgill and Ms. Kirchmeyer provided a power point presentation on investigation and prosecution timeframe statistics. The charts compare timelines for prosecuting cases before the vertical enforcement (VE) model and after the VE model. In addition, statistics were compared for investigations that were closed without proceeding to disciplinary action for pre VE cases and post VE cases.

Mr. Zerunyan stated he has a few concerns and a possible future agenda item to consider. He noted it is important to see these timelines and the process of what he considers the most important function of public protection. Although these are valiant efforts, the timeframes given are unsatisfactory from a public protection standpoint. He requested staff report on recommendations for timeline reductions as a future agenda item.

Ms. Threadgill responded following an LA Times article, staff began exploring ways to decrease the enforcement process timeframes. Staff identified there is duplication in requesting records She suggested the Board seek legislation to mandate certification of records requested by the Medical Board.

It was m/Gitnick, s/Yaroslavsky to seek legislation this year to require entities to provide certified medical records to the Board upon request.

Dr. Aristeiguieta asked legal staff to clarify if the Board can continue discussion on an item which is not on the agenda.

Ms. Scuri suggested it would be more appropriate to consider this issue under the legislative portion of the agenda.

Agenda Item 16 Vertical Enforcement Update

Ms. Threadgill and Mr. Ramirez reported the Joint Guidelines have been completed.
Mr. Ramirez stated he would be happy to answer any questions the Board may have.

Dr. Salomonson asked for clarification regarding the prioritizing of cases.

Mr.Ramirez responded the legislature has set forth priorities for case processing. In addition, any case that poses an imminent risk to the public is given the highest priority.

Dr. Gitnick, stated he was impressed with the data but concerned even in the best cases it is taking hundreds of days to completion. He asked if there is anything the Board can do to shorten this period of time.

Mr. Ramirez stated he will provide recommendations to reduce the timeframes at the July meeting.

Mr. Zerunyan asked if there is any further information on the development of a new information technology system.

Angelo Whitfield, Information Technology Consultant, Department of Justice, reported HQE and the Board have begun to share information.

Public Comment was heard by:

- Tina Minasian thanked the Board for all they do to protect the public. She was a victim of a doctor in Diversion and is concerned timeframes have hindered the process of justice.

- Tara Kittle commented it takes too long for a case to be finalized. She suggested the Board go back to the legislature.

Agenda Item 17 Diversion Program Update

Frank Valine, Diversion Program Manager, directed the members' attention to page 172 of their Board packet and provided information on the quality review report for the period of January 1, 2008 through March 31, 2008.

Mr. Valine directed the members' attention to page 185 of their Board packet regarding the Collection System Manager Report and to page 190, the Diversion Program Summit Meeting Summary of public comments which will be posted on the Medical Board's Web site.

Mr. Valine stated the Diversion Program's transition plan will be fully implemented by June 30, 2008.

Public comment was heard from Francine Farrell, Pacific Assistance Group who expressed concern regarding the termination of the Diversion Program. They support the Board's desire to set standards and require education.

Agenda Item 18 Legislation

Dr. Fantozzi asked Dr. Gitnick if he would like to take this opportunity to bring his motion forward regarding medical records.

It was m/Gitnick, s/Yaroslavsky, c/All to seek legislation this year to require entities provide certified medical records to the Board upon request.

Linda Whitney, Chief of Legislation, provided an update on legislative outreach efforts and reported the Enforcement Program Supervisors have almost completed visits to legislative district offices. She stated this was an excellent outreach opportunity and she thanked the enforcement staff for their efforts.

Ms. Whitney reported she is working on pursuing amendments to legislation regarding licensing issues related to the panels.

Ms. Whitney reported the licensing program recognized a technical flaw in the renewal codes for the 2168 Special Faculty Permit holder which excludes individuals from the requirements of continuing medical education (CME). Ms. Whitney requested authorization to move forward with amendments to fix the legislation.

It was m/Yaroslavsky, s/Alexander to seek legislation that adds CME requirements for Special Faculty Permit registrants.

Ms. Whitney reported she has been in discussions with Dr. Nakanishi regarding the $500,000 loan repayment program urgency measure and will be working on this in the near future.

Ms. Whitney directed the members' attention to their legislative packet and provided an update on 2008 legislation.

- AB 547 (Ma) - Cap on Fees. She has asked for an amendment to allow for a range in the months we have in our reserve. No action needed.

Dr. Fantozzi asked Spencer Walker, Deputy Director, DCA, if he would work with Ms. Whitney to get an opinion from the DCA on this subject.

- AB 1154 (Leno) - Diabetes. No action needed.

- AB 1944 (Swanson) - Corporate Practice of Medicine. Ms. Whitney recommended the Board oppose the bill.

It was M/S/C to oppose the bill.

Brett Michelin representing the CMA spoke in support of staff's recommendation to oppose this bill. He also stated they support AB 1640 and SB 1294.

- AB 1951 (Hayashi) - Psychiatrists; suicide prevention training. Ms. Whitney recommended the Board oppose unless amended.

Mr. Alexander asked if we could change the position to support if amended.

Ms. Whitney explained that "oppose unless amended" is considered neutral; "support with amendments" is not considered neutral.

It was m/Alexander, s/Yaroslavsky, to oppose unless amended.

Dr. Gitnick asked whether the wording could be interpreted as requiring the medical school to provide this form of training or is the bill limited to CME requirements.

Ms. Whitney responded this bill requires all medical school to include this training.

Dr. Gitnick respectfully opposed this bill and stated he does not believe the legislature should be telling medical schools what they should or should not teach without the input of the medical schools.

Mr. Alexander accepted the amendment to the motion to oppose the bill. It was m/Alexander, s/Yaroslavsky, c/All to oppose the bill

- AB 2398 (Nakanishi) - **Cosmetic Surgery/Supervision.** Ms. Whitney recommended the Board support this bill.

It was m/Alexander, s/Yaroslavsky to support the bill.

Public comments were heard from the following:

Celia Remy, MD, Vitality Medical	opposed
Missey Mc Callum, R.N. Dignity Medical Aesthetics	opposed
Pamela Linney, R.N.	opposed
Dennis Harper, owner American Laser Centers	opposed
Will Kirby, M.D., General Public	opposed
Lori Haney, R.N., Celibre Medical	opposed
Cyndi Howard, R.N., American Laser Centers	opposed
Anne Morleand, R.N. Bay Area Body Enhancement Clinic	opposed
Marla Bettencourt, R.N., Medi Spa Radience	opposed
Norman Davis, Esq., California Med Spa Mngt Assoc.	opposed
Hermine Warren, Assoc. of Medical Nurses	opposed
Carrie Edler, R.N., General Public	opposed
Thomas Simerson, M.D., General Public	opposed
Jamie Warner, R.N., Belle Visage Medical	opposed
Christian Jagusch, M.D., South Coast Med Spa	opposed
Michele Panora, Vitality Medical Laser Clinic	opposed
Stephen Moore, General Public	support
Kathleen Creason, Executive Director, OPSC	support
John Valencia, Wilke, Fleury, Hoffelt, Gould & Birney, LLP	support
Sherellen Gerhart, M.D., Self and Dignity Medical	opposed
Alan Voss, General Public	opposed

Ms. Salomonson stated she does not believe AB 2398 addresses the concerns of training and recommended the Board oppose AB 2398 as written. She also recommended the Board move forward with re-activating Operation Safe Medicine and enforcing the statutes currently in place.

It was m/Alexander, s/Yarolslavsky, c/All to amend the recommendation of the staff's report to a watch position on AB 2398 and direct staff to work with the Board of Registered Nursing to communicate the emphasis on patient safety to the author.

- AB 2439 (De La Torre) Loan Repayment Program. Ms. Whitney recommended the Board oppose unless amended to lower the mandatory fee to $25 or less.

It was m/Gitnick, s/Yaroslavsky, c/All to support if amended to remove the 15% allocation for geriatric medicine and reduce the $50 fee to $25.

- AB 2442 (Nakanishi) Peer Review Proceedings. This is the Board sponsored bill which would repeal B & P Code 821.5 and 821.6. This bill is on the Assembly floor.

- AB 2443 (Nakanishi) Physician Well Being. This is the Board sponsored bill which would establish a well being program. This bill is in the Assembly Appropriations and has been placed on suspense. Proposed amendments have been submitted to clarify that the program will be developed within existing resources.

Brett Michelin, CMA stated they have not taken a position on AB 2443 but believes there should be some parameters placed in the bill with regard to fiscal consideration.

- AB 2444 (Nakanishi) Public Letters of Reprimand with Education. This is a board sponsored bill. This bill would allow the Board to impose specific educational requirements in conjunction with public letters of reprimand. The bill is on the Assembly Floor.

- AB 2445 (Nakanishi) Public Letters of Reprimand at time of initial licensure. This is a Board sponsored bill. This would allow issuance of public letters of reprimand at initial licensure. The bill is on the Assembly Floor.

- AB 2482 (Maze) Physician's Assistants; continuing education. This bill would allow PAC to require continuing education. Ms. Whitney recommends the Board support this bill.

It was m/Low, s/Alexander, c/All to support the bill.

- AB 2516 (Mendoza) Prescriptions; electronic transmission. This bill would require physicians to send prescriptions electronically to a patient's pharmacy of choice. Amendments add that transmission must be type written. Ms. Whitney recommended support if amended to provide an exemption or extended implementation date for special cases appealed to the Pharmacy Board.

It was m/Alexander, s/Shipske to support if amended to provide an exemption or extended implementation date for special cases appealed to the Pharmacy Board.

Ms. Whitney stated she was just informed the author was pulling the bill. No further action required.

- AB 2543 (Berg) Loan Repayment Program; geriatric. This bill would require that 15% of available money be applied to physicians in a geriatric setting. Ms. Whitney recommended the Board oppose this bill.

It was m/Aristeguieta, s/Yarolslavsky, c/All to oppose the bill.

- AB 2649 (Ma) Medical Assistants; authorized services. This bill would specify the provisions that allow a medical assistant to perform services relating to the administration of certain procedures. Clarifies current laws and might be unnecessary. Ms. Whitney recommended the Board take a neutral position on this bill.

It was m/Yarolslavsky, s/Alexander, c/All to take a neutral position on the bill.

- AB 2734 (Krekorian) Advertisements; license number and Board Web site. This bill would require on July 1, 2009 that business cards of physicians include the licensing

agency and a valid license number or fictitious name permit number. Ms. Whitney recommended the Board support this bill.

It was m/Alexander, s/Zerunyan, c/All to support the bill

- AB 2747 (Berg) End of Life Care. This bill requires attending physicians, when making a diagnosis that a patient has a terminal illness, to provide the patient an opportunity to receive information and counseling regarding all legal end of life care options, if the patient requests the information. Ms. Whitney recommended the Board take a neutral, if amended, position to clarify that materials or information should be provided.

It was m/Durussieau, s/Alexander to take a neutral, if amended, position on this bill. The motion carried. (1 abstained)

- AB 2841 (Ma) Medical Procedures; reusable adipose cannula. This bill requires patients be notified through a written disclosure statement prior to any medical procedure in which a reusable cannula is to be used. Ms. Whitney recommended the Board oppose this bill.

It was m/Alexander, s/Yaroslavsky, c/All to oppose the bill.

- AB 2968 (Carter) Cosmetic Surgery; physical exam. This bill would prohibit elective cosmetic surgery on a patient unless prior to surgery, the patient has completed a physical exam by and has received written clearance for the procedure from a physician. The amendment allows a dentist with a permit to perform facial cosmetic surgery to perform that physical. Ms. Whitney recommended oppose unless amended to allow those healthcare practitioners who are authorized to perform physical examinations to be able to complete physical exams for patients.

It was m/Yaroslavsky, s/Alexander, c/All to oppose the bill unless amended.

- AB 2969 (Lieber) Worker's Compensation; medical treatment utilization reviews. This bill would require a physician who is conducting utilization review to be licensed in California. Ms. Whitney recommended the Board support this bill.

It was m/Yaroslavsky, s/Alexander to support the bill.

Carl Brakensiek, California Society of Industrial Medicine and Surgery, spoke in support of the bill.

Dr. Fantozzi called for the motion. The motion carried.

- SB 797 (Ridley-Thomas) Vertical Enforcement/Prosecution extension. Ms. Whitney reported this bill was amended and an urgency provision has been placed in the bill. This bill is the extension of the Vertical Enforcement/Prosecution model. This bill would clearly state the investigators are not under the supervision of the deputy attorney general

and also states the intent for the Medical Board to increase its computer capabilities with HQES and states intent to implement a plan to co-locate offices.

- SB 1294 (Ducheny) Employed Physicians; pilot project. This bill makes minor changes to the Board's current pilot program which allows for the direct employment of physicians and surgeons by qualified health districts. Ms. Whitney recommended the Board support this bill.

Dr. Aristeiguieta recommended the Board oppose this bill. His concern is physicians should have independent judgment and not be threatened by their employment status.

Ms. Scuri asked if Dr. Aristeiguieta would support this bill if amended to add a provision to clarify that district hospitals will not interfere with the independent judgment of the physician.

Ms. Whitney stated the Board can take a neutral position on the bill and she can bring information to the members at the July meeting.

It was m/Aristeiguieta, s/Alexander, c/All to take a neutral position on this bill.

- SB 1379 (Ducheny) Loan Repayment; permanent funding source. This bill would prohibit the Department of Managed Health Care from using fines and penalty revenues to reduce assessments levied on health care service plans and redirects these penalty revenues to the Physician Corps Loan Repayment Program. Ms. Whitney recommended the Board support this bill.

It was m/Aristeiguieta, s/Duruisseau, c/All to support this bill.

- SB 1394 (Lowenthal) Lapses of Consciousness; reports to DMV. This bill authorizes a physician to report to the DMV information relating to a patient whom he has diagnosed having suffered a lapse of consciousness when it serves public safety and interest. Ms. Whitney recommended the Board support this bill.

It was m/Yaroslavsky, s/Gitnick, c/All to support this bill.

- SB 1415 (Kuehl) Medical Record Retention and Storage. This bill requires a health care provider when creating an initial patient record on or after January 1, 2009 to include a signed disclosure of the patient's right to obtain or inspect the medical records and provides record retention policies. Ms. Whitney recommended the Board support this bill.

It was m/Yaroslavsky, s/Zerunyan, c/All to support this bill.

- SB 1454 (Ridley-Thomas) Advertising, Cosmetic Surgery Standards. This bill contains several provisions related to cosmetic surgery and advertising. It requires the Board to adopt regulations on the appropriate level of supervision necessary within clinics using lasers or intense pulse light devises and requires the Board to post on its Web site a fact

sheet to educate the public on cosmetic surgery. This bill will also place as a priority, the investigation of Corporate Practice of Medicine issues. Ms. Whitney recommended the Board support this bill.

It was m/Yaroslavsky, s/Zerunyan, c/All to support this bill.

- SB 1441 (Ridley-Thomas) Task force; address standards for impaired licensees programs. This bill creates a task force to address standards for impaired licensee programs. It would specify legislative intent that the Bureau of State Audits conducts a thorough performance audit of diversion programs to evaluate the effectiveness and efficiency of the programs. Ms. Whitney recommended support if amended to require both committees to have provider expertise.

It was m/Aristeiguieta, s/Yaroslavsky, c/All to support the bill.

- SB 1526 (Perata) Polysomnographic Technologists. This bill requires the Board to adopt regulations by July 1, 2009 to establish qualifications for certified polysomnographic technologists. Ms. Whitney recommended the Board take a neutral position on this bill

  and assign a Board member to work with staff to discuss it with the author's office.

It was m/Yaroslavsky, s/Aristeiguieta to take a neutral position on this bill.

The Board heard public comment from:

Clete Kushida, M.D., Ph.D., California Sleep Society, spoke in support of the bill.
David Gonzalez, American Academy of Sleep Medicine, Sponsor/supports the bill.
Stephanie Nunez, Executive Officer, Respiratory Care Board, spoke in support with modifications to the bill.
Mark Goldstein, Respiratory Care Practitioner, spoke in support with modification to the bill.

Dr. Fantozzi called for the motion. The motion carried.

Dr. Fantozzi interrupted to state there is no longer a quorum of the Board. He explained the members, acting as a committee, could proceed to discuss and make recommendations to the full Board.

- SB 1579 (Calderon) Referrals for Hair Restoration. This bill would allow physicians to offer compensation to licensed barbers or cosmetologists for providing general hair restoration information or education to a client, including referring or recommending the client to a physician for consultation regarding hair restoration. Ms. Whitney recommended the Committee oppose the bill.

It was m/Yaroslavsky, s/Duruisseau, c/All to make a recommendation to the full Board to oppose this bill.

- SB 1779 Healing Arts; Omnibus. This bill includes the amendments to certain board statutes. The Board has taken a support position on this bill.

The Board took the following positions on legislation:

AB 547 (Ma)	Cap on Fees	**Support if Amended**
AB 1154 (Leno)	Diabetes	**Refer to Access to Care**
AB 1944 (Swanson)	Corporate Practice of Medicine	**Oppose**
AB 1951 (Hayashi)	Psychiatrists; suicide prevention training	**Oppose**
AB 2398 (Nakanishi)	Cosmetic Surgery/Supervision	**Watch Position**
AB 2439 (De La Torre)	Loan Repayment Program	**Support if Amended**
AB 2442 (Nakanishi)	MBC: Peer Review Proceedings	**Sponsor/Support**
AB 2443 (Nakanishi)	MBC: Physician Well Being	**Sponsor/Support**
AB 2444 (Nakanishi)	MBC: Public Letters of Rep. with Education	**Sponsor/Support**
AB 2445 (Nakanishi)	MBC: Licensing Public Letters of Reprimand	**Sponsor/Support**
AB 2482 (Maze)	Physician Assistants; continuing education	**Support**
AB 2516 (Mendoza)	Prescriptions: electronic transmission	**Pulled**
AB 2543 (Berg)	Loan Repayment Program; geriatric	**Oppose**
AB 2649 (Ma)	Medical Assistants; authorized services	**Neutral**
AB 2734 (Krekorian)	Advertisements: license # and MBC Website	**Support**
AB 2747 (Berg)	End of Life Care	**Neutral if Amended**
AB 2841 (Ma)	Medical Procedures; reusable adipose cannula	**Oppose**
AB 2968 (Carter)	Cosmetic Surgery; physical exam	**Oppose unless Amended**
AB 2969 (Lieber)	Worker's Compensation: medical treatment utilization reviews	**Support**
SB 797 (Ridley-Thomas)	VE/P Extension	**Support**
SB 1294 (Ducheny)	Employed Physicians; pilot project	**Neutral**
SB 1379 (Ducheny)	Loan Repayment: permanent funding source	**Support**
SB 1394 (Lowenthal)	Lapses of Consciousness; reports to DMV	**Support**
SB 1415 (Kuehl)	Medical Record Retention and Storage	**Support**
SB 1441 (Ridley-Thomas)	Task Force; address standards for impaired	**Support if Amended**
SB 1454 (Ridley-Thomas)	Advertising, Cosmetic Surgery Standards	**Support**
SB 1526 (Perata)	Polysomnographic Technologists	**Neutral**
SB 1579(Calderon)	Referrals for Hair Restoration	**Support**
SB 1779 (SB & P)	Healing Arts:Omnibus	**Support**

Agenda Item 19 Victims Compensation Program Presentation

Dr. Fantozzi announced in view of the time constraints this item will be rescheduled to another meeting.

Agenda Item 20 Agenda Items for July 2008 Meeting

There were no additional future agenda items presented.

Agenda Item 27 Adjournment

There being no further business, it was M/S/C to adjourn the meeting at 2:15 p.m.

_____
Richard Fantozzi, M.D, President

_____
Cesar Aristeiguieta, M.D., Vice President

_____
Barb Johnston, Executive Director

State Budget Status and Budget Expenditures Status Report

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	LICENSING	ADMIN SERVICES	DIVERSION	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 04/05								
$ Budgeted	1,504,000	28,428,000	3,482,000	1,750,000	1,194,000	2,548,000	2,117,000	41,023,000
$ Spent*	1,419,000	27,264,000	3,151,000	1,774,000	1,054,000	2,298,000	1,340,000	38,300,000 *
Positions								
Authorized	8.0	137.6	37.2	20.0	12.0	15.0	23.0	252.8
FY 05/06								
$ Budgeted	1,531,000	29,371,000	3,567,000	1,814,000	1,189,000	2,711,000	2,399,000	42,582,000
$ Spent *	1,412,000	26,380,000	3,170,000	1,756,000	1,148,000	2,438,000	1,406,000	37,710,000 *
Positions								
Authorized	8.0	137.6	37.2	20.0	12.0	15.0	23.0	252.8
FY 06/07								
$ Budgeted	1,534,000	34,693,000	3,949,000	3,089,000	1,747,000	2,857,000	2,591,000	50,460,000
$ Spent *	1,555,000	30,572,000	3,517,000	2,756,000	1,683,000	2,393,000	1,495,000	43,971,000 *
Positions								
Authorized	8.8	141.6	40.5	19.4	14.0	16.0	25.0	265.3
FY 07/08								
$ Budgeted	1,896,000	35,696,000	4,334,000	2,855,000	1,397,000	3,078,000	2,750,000	52,006,000
$ Spent thru 5/31*	1,388,000	30,750,000	3,811,000	1,927,000	999,000	2,541,000	1,568,000	42,984,000 *
Positions								
Authorized	8.8	147.6	44.5	15.0	14.0	16.0	19.0	264.9

* net expenditures (includes unscheduled reimbursements)

6/27/2008
Budget Overview by Program.xls

Medical Board of California

FY 07/08

Budget Expenditure Report

(As of May 31, 2008)

(91.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	15,306,508	12,410,938	81.1	2,895,570
DEC	24,000	15,000	62.5	9,000
Board Members	31,500	23,800	75.6	7,700
Phy Fitness Incentive Pay	29,623	22,165	74.8	7,458
Temp Help	1,144,410	1,466,849	128.2	(322,439)
Allocated Proctor	0	258		(258)
Overtime	12,143	77,398	637.4	(65,255)
Staff Benefits	6,485,271	5,286,489	81.5	1,198,782
Salary Savings	(803,979)			(803,979)
TOTALS, PERS SERVICES	22,229,476	19,302,897	86.8	2,926,579
OPERATING EXP & EQUIP				
General Expense	891,585	351,207	39.4	540,378
Fingerprint Reports	373,448	292,599	78.4	80,849
Printing	835,648	463,185	55.4	372,463
Communications	567,855	256,229	45.1	311,626
Postage	444,459	268,596	60.4	175,863
Insurance	37,956	9,843	25.9	28,113
Travel In-State	421,039	336,103	79.8	84,936
Travel Out-of-State	2,800	437	15.6	2,363
Training	62,910	71,857	114.2	(8,947)
Facilities Operation (Rent)	2,784,152	2,216,550	79.6	567,602
Consult/Prof Services	1,369,919	1,288,609	94.1	81,310
Departmental Prorata	4,028,381	3,688,399	91.6	339,982
Consolidated Data Ctr (Teale)	572,639	233,944	40.9	338,695
Data Processing	106,263	222,465	209.4	(116,202)
Central Admin Svcs (Statewide Prorata)	1,793,449	1,794,015	100.0	(566)
Attorney General Services	12,419,270	11,247,863	90.6	1,171,407
Office of Administrative Hearings	1,643,939	1,241,111	75.5	402,828
Court Reporter Services	160,000	113,855	71.2	46,145
Evidence/Witness	1,676,318	1,104,993	65.9	571,325
DOI-Investigations	2,434	2,233	91.7	201
Major Equipment	232,300	165,339	71.2	66,961
Minor Equipment	182,300	431,791	236.9	(249,491)
Vehicle Operation/Other Items	242,370	346,089	142.8	(103,719)
Special Adjustments (OE&E)	0	(1,362)		1,362
Debt Service-Interest on Settlement	0	2,286		(2,286)
TOTALS, OE&E	30,851,434	26,148,236	84.8	4,703,198
TOTALS, EXPENDITURES	53,080,910	45,451,133	85.6	7,629,777
Scheduled Reimbursements	(384,000)	(323,015)	84.1	(60,985)
Distributed Costs	(691,000)	(743,267)	107.6	52,267
NET TOTAL, EXPENDITURES	52,005,910	44,384,851	85.3	7,621,059
Unscheduled Reimbursements		(1,400,610)		
		42,984,241		

Budget Expenditure Report.xls

Date: June 23, 2008

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)

#1: Planned Budget

		ACTUAL 2006-07	2007-08	2008-09	2009-10	2010-11
BEGINNING BALANCE		$ 12,199	$ 18,467	$ 11,144	$ 8,898	$ 4,329
Prior Year Adjustment		$ 576	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 12,775	$ 18,467	$ 11,144	$ 8,898	$ 4,329
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 348	$ 354	$ 366	$ 366	$ 366
125700	Other regulatory licenses and permits	$ 5,703	$ 5,693	$ 5,707	$ 5,707	$ 5,707
125800	Renewal fees	$ 42,415	$ 42,834	$ 43,233	$ 43,639	$ 44,038
	Reduced fees per elim of Diversion Program			$ (1,213)	$ (1,213)	$ (1,213)
125900	Delinquent fees	$ 94	$ 92	$ 100	$ 100	$ 100
141200	Sales of documents	$ -	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ 25	$ 25	$ 25	$ 25	$ 25
150300	Income from surplus money investments	$ 1,088	$ 816	$ 448	$ 206	$ -
160400	Sale of fixed assets		$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ 11	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ 4	$ 6	$ 6	$ 6	$ 6
164300	Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 49,688	$ 50,720	$ 49,572	$ 49,736	$ 49,929
Transfers:						
Trans to Steven M. Thompson Phys Corp Loan Repayment Prgm				$ (500)		
Loan:						
General Fund Loan per May Revise			$ (6,000)			$ 6,000
Totals, Revenues and Transfers		$ 49,688	$ 44,720	$ 49,072	$ 49,736	$ 55,929
Total Resources		$ 62,463	$ 63,187	$ 60,216	$ 58,634	$ 60,258
EXPENDITURES						
0840 State Controller (State Operations)		$ 25	$ 37	$ 36	$ -	$ -
1110 Program Expenditures (State Operations)		$ 43,971	$ 51,606	$ 51,282	$ 52,308	$ 53,354
	Peer Review Study		$ 400			
	Proposed BCP: Operation Safe Medicine				$ 1,126	$ 1,126
	Proposed BCP: Probation Program Expansion				$ 601	$ 476
	Proposed BCP: Replace IT Infrastructure				$ 270	$ 459
Total Expenditures and Expenditure Adjustments		$ 43,996	$ 52,043	$ 51,318	$ 54,305	$ 55,415
FUND BALANCE						
Reserve for economic uncertainties		$ 18,467	$ 11,144	$ 8,898	$ 4,329	$ 4,844
Months in Reserve		4.3	2.6	2.0	0.9	1.0

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED.

B. INTEREST ON FUND ESTIMATED AT 5% BEGINNING FY 07/08.

7/2/2008

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2005 - MAY 2008

	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	FYTD Total
Invest Cost Recovery	50,749	89,190	48,074	92,811	64,158	51,605	79,797	44,058	32,282	51,377	25,267	12,829	642,197
*Invest Cost Recovery Ordered**	*43,797*	*49,467*	*140,574*	*46,665*	*75,155*	*72,133*	*59,294*	*11,500*	*29,500*	*10,000*	*0*	*0*	*538,085*
Criminal Cost Recovery	1,350	16,822	746	1,151	8,570	760	586	5,661	5,489	690	600	730	43,155
Probation Monitoring	36,707	14,612	7,909	46,661	97,709	111,055	239,827	229,080	31,782	41,281	30,624	27,579	914,826
Exam	2,611	825	4,057	11,997	4,111	360	3,936	2,089	602	2,713	1,793	4,600	39,694
Cite/Fine	1,350	1,450	0	5,175	9,100	175	4,150	7,900	3,850	850	5,300	5,000	44,300
MONTHLY TOTAL	92,767	122,899	60,786	157,795	183,648	163,955	328,296	288,788	74,005	96,911	63,584	50,738	1,684,172
FYTD TOTAL	92,767	215,666	276,452	434,247	617,895	781,850	1,110,146	1,398,934	1,472,939	1,569,850	1,633,434	1,684,172	

	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	FYTD Total
Invest Cost Recovery	21,173	30,787	19,692	22,508	22,790	10,741	26,503	6,342	13,891	18,577	11,064	6,789	210,857
*Invest Cost Recovery Ordered**	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Criminal Cost Recovery	450	704	57,971	1,100	840	373	1,213	750	100	10,200	18,704	2,689	95,094
Probation Monitoring	28,503	30,868	8,857	14,327	123,405	112,580	332,202	155,028	33,356	42,898	27,181	22,842	932,047
Exam	4,456	5,843	3,093	1,065	2,440	1,561	7,215	1,505	3,858	3,105	515	6,256	40,912
Cite/Fine	4,675	3,600	3,750	7,420	8,150	4,350	5,000	4,700	2,950	10,960	5,700	650	61,905
MONTHLY TOTAL	59,257	71,802	93,363	46,420	157,625	129,605	372,133	168,325	54,155	85,740	63,164	39,226	1,340,815
FYTD TOTAL	59,257	131,059	224,422	270,842	428,467	558,072	930,205	1,098,530	1,152,685	1,238,425	1,301,589	1,340,815	

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	FYTD Total
Invest Cost Recovery	15,074	12,725	13,851	10,837	7,104	6,432	14,100	15,947	3,307	15,221	6,086		120,684
Criminal Cost Recovery	0	0	0	0	0	2,975	0	0	50,000	0	0		52,975
Probation Monitoring	31,949	49,534	24,134	32,231	119,692	140,590	247,147	220,081	27,151	62,498	39,786		994,793
Exam	3,545	4,227	1,248	1,820	1,209	300	905	2,055	2,265	6,530	1,080		25,184
Cite/Fine	1,200	9,100	6,250	4,800	13,440	1,850	1,700	3,500	14,900	5,731	6,200		68,671
MONTHLY TOTAL	51,768	75,586	45,483	49,688	141,445	152,147	263,852	241,583	97,623	89,980	53,152	0	1,262,307
FYTD TOTAL	51,768	127,354	172,837	222,525	363,970	516,117	779,969	1,021,552	1,119,175	1,209,155	1,262,307	1,262,307	

**not included in monthly and FYTD totals*

excel:enfreceiptsmonthlyprofile.xls.revised 6/24/08.

NOTE: cost recovery shown ordered after 1/1/06 was ordered in stipulations prior to 1/1/06

Medical Board of California
Board Members' Expense Report
July 1, 2007 - May 31, 2008

	*Per Diem**				*Travel Expenses**	*Total Mar-May*	***Total FYTD***
	MAR	APR	MAY	TOTAL			
Mr. Alexander	200	500	400	1,100	704.94	1,804.94	5,961.67
Dr. Aristeiguieta	0	0	0	0	0.00	0.00	0.00
Ms. Chang	200	0	0	200	523.80	723.80	882.30
Dr. Chin	0	0	0	0	0.00	0.00	711.25
Dr. Corday	0	0	0	0	0.00	0.00	728.50
Dr. Duruisseau	0	600	400	1,000	125.20	1,125.20	5,229.06
Dr. Fantozzi	600	900	700	2,200	1,570.72	3,770.72	15,606.26
Dr. Gitnick	0	0	0	0	735.56	735.56	735.56
Dr. Gregg	0	0	0	0	0.00	0.00	1,577.50
Dr. Low	0	0	0	0	0.00	0.00	200.00
Dr. Moran	0	0	0	0	0.00	0.00	0.00
Dr. Salomonson	0	0	0	0	0.00	0.00	3,657.58
Ms. Schipske	200	300	0	500	899.05	1,399.05	3,675.20
Dr. Wender	0	200	0	200	402.97	602.97	2,768.95
Ms. Yaroslavsky	0	0	0	0	0.00	0.00	0.00
Mr. Zerunyan	400	900	300	1,600	700.03	2,300.03	7,101.15
BOARD TOTAL	1,600	3,400	1,800	6,800	5,662.27	12,462.27	**48,834.98**

*includes claims paid/submitted through June 27, 2008

Board Members Expense Report.xls
Date: June 30, 2008

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE PROGRAM
BUDGET REPORT
JULY 1, 2007 - MAY 31, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	642,738	583,485	current
Staff Benefits	258,625	185,774	current
TOTAL PERSONAL SERVICES	901,363	769,259	
OPERATING EXPENSE & EQUIPMENT			
General Expense 1/	70,500	64,956	1-2
Printing	300,000	36,290	1-2
Communications	26,292	8,388	1-2
Postage	181,375	111,301	1-2
Travel In-State	105,455	71,869	1-2
Travel Out-of-State	800	437	current
Training	5,000	6,790	1-2
Facilities Operations 2/	72,000	67,045	current
Consultant & Professional Services	24,000	15,890	1-2
Departmental Services 3/	143,813	132,776	current
Other Items of Expense	0	207	1-2
Data Processing	1,000	6,343	1-2
Central Administrative Services 4/	64,026	64,046	current
DOI-Investigations	0	79	current
Minor Equipment	0	32,001	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	994,261	618,418	
TOTAL BUDGET/EXPENDITURES	**1,895,624**	**1,387,677**	

See footnotes on next page

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1/ costs for employee relocation, miscellaneous office supplies, freight and drayage, General Services administration overhead (charges levied by the Department of General Services for purchase orders, contracts, traffic management, fleet administration, and confidential destruction; charges levied by the State Controller's Office for the processing of disability insurance claims, late payroll document costs; by EDD for unemployment insurance and by DPA Admininstration; charges levied by any other state agency for services provided not under contract), meetings and conferences, library purchases and subscriptions, photography, and office equipment rental, maintenance and repairs.

2/ rent, security, maintenance, facility planning, waste removal, purchase of building supplies and materials.

3/ Department of Consumer Affairs prorata assessments for support of the following:

a/ Public Affairs Division
b/ Consumer and Community Relations Division
c/ Administrative & Information Services Division
d/ Division of Investigation Special Operations Unit

4/ Charges for support of the State Personnel Board, Department of Finance, State Controller, State Treasurer, Legislature, Governor's Office, etc.

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2007 - MAY 31, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	9,181,962	7,921,823	current
Staff Benefits	3,555,428	3,007,419	current
TOTAL PERSONAL SERVICES	12,737,390	10,929,242	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	256,104	104,350	1-2
Printing	373,148	318,028	1-2
Communications	310,994	144,805	1-2
Postage	101,806	61,330	1-2
Insurance	29,930	7,177	current
Travel In-State	122,358	130,709	1-2
Travel Out-of-State	900	0	current
Training	21,806	42,223	1-2
Facililties Operations	1,622,789	1,582,580	current
Consultant/Professional Services	750,000	659,721	1-2
Departmental Services	2,758,232	2,511,798	current
Data Processing	12,000	15,427	1-2
Central Administrative Services	1,227,975	1,228,356	current
Attorney General 1/	12,229,270	11,102,351	current
OAH	1,643,939	1,241,111	current
Evidence/Witness Fees	1,606,750	1,070,682	1-2
DOI-Investigations	2,434	1,523	current
Court Reporter Services	160,000	113,855	1-2
Major Equipment	112,800	33,416	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	72	67,159	1-2
Vehicle Operations	184,098	205,189	1-2
Minor Equipment	65,500	57,516	1-2
Special Adjust-OE&E	0	(1,362)	
Interest-Settlement	0	2,286	
TOTAL OPERATING EXPENSES & EQUIPMENT	23,592,905	20,700,230	
DISTRIBUTED COSTS	(634,562)	(700,939)	
TOTAL BUDGET/EXPENDITURES	**35,695,733**	**30,928,533**	
Unscheduled Reimbursements		(178,326)	
		30,750,207	

1/See next page for monthly billing detail

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MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 07/08
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	6,180.75	158.00	976,558.50
	Paralegal Services	134.00	101.00	13,534.00
	Auditor/Analyst Services	4.00	63.00	252.00
	Cost of Suit			
				990,344.50
August	Attorney Services	6,933.50	158.00	1,095,493.00
	Paralegal Services	65.25	101.00	6,590.25
	Auditor/Analyst Services	6.00	63.00	378.00
	Cost of Suit			828.50
				1,103,289.75
September	Attorney Services	6,143.50	158.00	970,673.00
	Paralegal Services	240.00	101.00	24,240.00
	Auditor/Analyst Services	69.50	63.00	4,378.50
	Cost of Suit			2,997.12
				1,002,288.62
October	Attorney Services	6,653.25	158.00	1,051,213.50
	Paralegal Services	241.50	101.00	24,391.50
	Auditor/Analyst Services	107.00	63.00	6,741.00
	Special Agent Services	2.00	110.00	220.00
	Cost of Suit			371.88
				1,082,937.88
November	Attorney Services	5,532.25	158.00	874,095.50
	Paralegal Services	253.50	101.00	25,603.50
	Auditor/Analyst	90.50	63.00	5,701.50
	Special Agent Services	10.00	110.00	1,100.00
	Cost of Suit			1,267.04
				907,767.54
December	Attorney Services	5,153.50	158.00	814,253.00
	Paralegal Services	227.75	101.00	23,002.75
	Auditor/Analyst	67.50	63.00	4,252.50
	Cost of Suit			4,315.06
				845,823.31

Revised 6/18/08

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 07/08
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

January	Attorney Services	6,339.75	158.00	1,001,680.50
	Paralegal Services	277.25	101.00	28,002.25
	Auditor/Analyst	85.75	63.00	5,402.25
	Special Agent Services	5.00	120.00	600.00
	Cost of Suit			3,417.85
				1,039,102.85
February	Attorney Services	5,958.50	158.00	941,443.00
	Paralegal Services	286.75	101.00	28,961.75
	Auditor/Analyst	79.50	63.00	5,008.50
	Cost of Suit			1,124.72
				976,537.97
March	Attorney Services	5,989.75	158.00	946,380.50
	Paralegal Services	278.25	101.00	28,103.25
	Auditor/Analyst Services	86.00	63.00	5,418.00
	Cost of Suit			13,022.55
				992,924.30
April	Attorney Services	6,703.50	158.00	1,059,153.00
	Paralegal Services	315.50	101.00	31,865.50
	Auditor/Analyst Services	107.50	63.00	6,772.50
	Cost of Suit			5,071.24
				1,102,862.24
May	Attorney Services	6,500.75	158.00	1,027,118.50
	Paralegal Services	235.50	101.00	23,785.50
	Auditor/Analyst Services	96.50	63.00	6,079.50
	Cost of Suit			1,488.79
				1,058,472.29
June	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			
				0.00

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07/08 FYTD Total =	**11,102,351.25**
07/08 FY Budget =	**12,229,270.00**

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2007 - MAY 31, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,858,777	1,663,591	current
Staff Benefits	821,753	696,971	current
TOTAL PERSONAL SERVICES	2,680,530	2,360,562	
OPERATING EXPENSES & EQUIPMENT			
General Expense	44,460	33,684	1-2
Fingerprint Reports*	369,948	288,944	current
Printing	100,000	89,402	1-2
Communications	73,816	42,637	1-2
Postage	137,446	94,124	1-2
Travel In-State	25,000	30,058	1-2
Training	4,000	2,925	1-2
Facilities Operation	185,000	197,257	current
Consult/Professional Services	448,919	594,069	1-2
Departmental Services	331,536	309,833	current
Data Processing	500	191	1-2
Central Administrative Services	147,601	147,656	current
Vehicle Operations	0	71	1-2
Attorney General	190,000	145,512	current
Evidence/Witness Fees	5,000	0	1-2
DOI-Investigations	0	188	current
Minor Equipment	0	9,543	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,063,226	1,986,094	
SCHEDULED REIMBURSEMENTS	(384,000)	(323,015)	
DISTRIBUTED COSTS	(26,089)	(19,567)	
TOTAL BUDGET/EXPENDITURES	**4,333,667**	**4,004,074**	
Unscheduled Reimbursements		(193,099)	
		3,810,975	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports

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MEDICAL BOARD OF CALIFORNIA
ADMINISTRATIVE SERVICES PROGRAM
BUDGET REPORT
JULY 1, 2007 - MAY 31, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	830,002	808,956	current
Staff Benefits	409,926	316,741	current
TOTAL PERSONAL SERVICES	1,239,928	1,125,697	
OPERATING EXPENSE & EQUIPMENT			
General Expense	433,121	97,751	1-2
Printing	30,000	11,808	1-2
Communications	80,435	23,331	1-2
Postage	10,131	313	1-2
Travel In-State	20,000	12,055	1-2
Training	3,000	98	1-2
Facilities Operations	695,363	159,079	current
Consultant & Professional Services	37,000	14,921	1-2
Departmental Services	229,215	213,935	current
Data Processing	1,000	56,618	1-2
Central Administrative Services	102,047	102,079	current
Vehicle Operations/Insurance/Other	2,445	4,018	1-2
DOI-Investigations	0	128	current
Major Equipment	0	42,728	1-2
Minor Equipment	0	84,285	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,643,757	823,147	
DISTRIBUTED COSTS	(28,357)	(21,267)	
TOTAL BUDGET/EXPENDITURES	**2,855,328**	**1,927,577**	

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MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
BUDGET REPORT
JULY 1, 2007 - MAY 31, 2008

	FY 07/08 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	720,179	528,838	73.4	current
Staff Benefits	319,115	175,894	55.1	current
TOTAL PERSONAL SERVICES	1,039,294	704,732	67.8	
OPERATING EXPENSES & EQUIPMENT				
General Expense	22,000	26,968	122.6	1-2
Printing	10,000	5,174	51.7	1-2
Communications	22,822	8,013	35.1	1-2
Postage	5,255	974	18.5	1-2
Insurance	1,702	516	30.3	current
Travel In-State	75,000	52,045	69.4	1-2
Travel Out-of-State	1,100	0	0.0	current
Training	4,418	616	13.9	1-2
Facilities Operation	30,000	35,356	117.9	current
Departmental Services	109,572	99,585	90.9	current
DP Maint/Supplies	500	0	0.0	1-2
Central Administrative Services	48,782	48,797	100.0	current
Major Equipment	16,000	0	0.0	current
Vehicle Operations	11,000	16,167	147.0	1-2
DOI-Investigations	0	57		
TOTAL OPERATING EXPENSES & EQUIPMENT	358,151	294,268	82.2	
TOTAL BUDGET/EXPENDITURES	**1,397,445**	**999,000**	71.5	

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MEDICAL BOARD OF CALIFORNIA
INFORMATION SYSTEMS PROGRAM
BUDGET REPORT
JULY 1, 2007 - MAY 31, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,036,606	987,589	current
Staff Benefits	474,219	339,690	current
TOTAL PERSONAL SERVICES	1,510,825	1,327,279	
OPERATING EXPENSE & EQUIPMENT			
General Expense	38,400	17,902	1-2
Printing	15,000	1,938	1-2
Communications	21,503	11,171	1-2
Postage	5,255	517	1-2
Travel In-State	21,441	5,821	1-2
Training	20,186	18,394	1-2
Facililties Operations	138,000	148,737	current
Consultant/Professional Services	110,000	4,008	1-2
Departmental Services	240,897	221,302	current
Consolidated Data Centers (Teale)	572,639	233,944	current
Data Processing	90,763	143,817	1-2
Central Administrative Services	107,248	107,281	current
Major Equipment	71,500	55,367	1-2
Minor Equipment	116,800	244,774	1-2
DOI-Investigations	0	135	current
TOTAL OPERATING EXPENSES & EQUIPMENT	1,569,632	1,215,108	
DISTRIBUTED COSTS	(1,992)	(1,494)	
TOTAL BUDGET/EXPENDITURES	**3,078,465**	**2,540,893**	

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MEDICAL BOARD OF CALIFORNIA
PROBATION MONITORING
BUDGET REPORT
JULY 1, 2007 - MAY 31, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,473,940	1,522,125	current
Staff Benefits	646,208	563,999	current
TOTAL PERSONAL SERVICES	2,120,148	2,086,124	
OPERATING EXPENSES & EQUIPMENT			
General Expense/Fingerprint Reports	30,500	9,251	1-2
Printing	7,500	545	1-2
Communications	31,993	17,884	1-2
Postage	3,191	37	1-2
Insurance	6,079	2,064	current
Travel In-State	51,785	33,545	1-2
Training	4,500	810	1-2
Facilities Operation	41,000	26,494	current
Departmental Services	215,116	199,170	current
Data Processing	500	70	1-2
Central/Administrative Services	95,770	95,800	current
Evidence/Witness Fees	64,568	34,311	1-2
DOI-Investigations	0	123	current
Major Equipment	32,000	33,829	1-2
Vehicle Operations/Other Items	45,000	53,364	1-2
Minor Equipment	0,000	3,672	
TOTAL OPERATING EXPENSES & EQUIPMENT	629,502	510,969	
TOTAL BUDGET/EXPENDITURES	**2,749,650**	**2,597,093**	
Unscheduled Reimbursements*		(1,029,185)	
		1,567,908	

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*no authority to spend

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6/23/2008

MEDICAL BOARD OF CALIFORNIA
Executive Office

Agenda Item 5B

PROPOSED SCHEDULE OF BOARD MEETING DATES FOR 2009

January 29, 30	Los Angeles
May 7, 8	San Francisco
July 23, 24	Sacramento
October 29, 30	San Diego

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 14, 2008
ATTENTION:	Board Members
DEPARTMENT:	Medical Board of California, Licensing Program
SUBJECT:	Recognition of International Medical School Programs
STAFF CONTACT:	Deborah Pellegrini, Chief, Licensing Program

The issue before the Board on this agenda item is the recognition of international medical schools – medical schools not located in the United States or Canada. The Board has promulgated regulations regarding the recognition of international medical schools. That regulation, Section 1314.1 of Title 16 of the California Code of Regulations is attached to Agenda Item 7A.

Essentially, the Board's regulation divides international medical schools into two types. The first type, commonly called "(a)(1)" schools in light of the Board's regulation, are schools opened and operated by the national government for the purpose of training that country's own citizens to practice medicine for the benefit of the country. California law does not require these schools to apply to the Board on their graduates' behalf to become eligible to train in and become licensed in California. In most cases, the national government bears the cost of the education of the students.

The second type of international medical schools called "(a)(2)" schools are medical schools that are not operated by the national government for the purpose of training its own citizens to practice medicine in that country. These schools are generally for-profit operations that accept students from all parts of the world. After receiving their medical education, these students then leave to practice medicine elsewhere, including California. These schools, which must apply to the Board for recognition, rely on tuition paid by the students to operate; there is little if any government subsidy or control.

In the 1990s, several Eastern European countries began opening and operating "English-language" programs at government medical schools. These operate alongside the government schools' preexisting medical education programs intended for their own citizens and taught in the native language. The English programs use the existing school's building and other resources, such as bilingual faculty who have the time available to teach additional classes in English. In other words, an (a)(1) school now offers an (a)(2) style education, because the English-language program trains paying students for practice elsewhere. These "English-language" programs also permit students to complete a few or all of their clinical rotations in hospitals in the U.S. and other countries.

Since the "English-language" programs do not comport to Section (a)(1) they must apply to the Board for recognition utilizing the established procedures.

This agenda item contains two of these "English-language" programs for your approval.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 11, 2008
ATTENTION:	Board Members
DEPARTMENT:	Medical Board of California, Licensing Program
SUBJECT:	Recognition of International Medical School Program Medical University of Lublin (English Program) Lublin, Poland
STAFF CONTACT:	Deborah Pellegrini, Chief, Licensing Program

REQUESTED ACTION:

Determine if the Medical University of Lublin's English-language program satisfies the minimum requirements of statute and regulation and should be granted recognition.

STAFF RECOMMENDATION:

Staff recommends that the Board grant recognition to the Medical University of Lublin's English Program, based on the Medical Consultant's positive findings and recommendations. This would be consistent with the Board's prior decisions regarding other European programs of this type.

EXECUTIVE SUMMARY:

The Medical University of Lublin in Lublin, Poland, founded its Polish-language medical school in 1949. In 1995, the institution began to operate a four-year medical education program for non-citizens using English as the language of instruction. A six-year English-language program was added in 1999 for applicants who have not completed the postsecondary pre-medical coursework to enter medical school.

The Board presently recognizes the Medical University of Lublin's Polish-language medical school whose primary purpose is to educate its own citizens to practice medicine in Poland. In accordance with Title 16, CCR, subsection (c) of section 1314.1, the Medical University of Lublin has requested the Board to grant recognition to its four-year and six-year English programs for foreign nationals. Subsection (a)(2) of section 1314.1 requires the institution to meet the standards set forth in subsection (b) of section 1314.1. Copies of B&P Code sections 2089 and 2089.5 and Title 16, CCR, section 1314.1 are attached for your reference.

The institution submitted a Self Assessment Report to the Board on March 3, 2008 and supplemental responses on May 10, 2008 and May 30, 2008. These items were forwarded to our Medical Consultant, Harold J. Simon, M.D., Ph.D., at the University of California, San Diego

(UCSD) for review. Dr. Simon is an expert medical education consultant and professor at the UCSD School of Medicine, Division of International Health and Cross-Cultural Medicine. Dr. Simon completed a comprehensive evaluation of the institution's Self Assessment Report and supporting data. Dr. Simon's June 11, 2008 report outlining his findings and recommendations is attached for your review. Institution officials addressed all questions and requests for additional information satisfactorily. Dr. Simon recommends that the Board grant recognition to Lublin's English programs with full retroactivity to prior students and graduates.

FISCAL CONSIDERATIONS:

There is no fiscal impact on the Medical Board of California to granting recognition to the Medical University of Lublin's English Program. If the Board grants recognition to the school's English program, graduates of the program will apply for licensure in California. The application processing fees that they remit will defray the costs of reviewing their applications.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

Since 2002, the Board's Division of Licensing has granted the same recognition to six English-language programs offered by existing native-language programs in Europe, including all four Hungarian medical schools and Charles University First Faculty of Medicine in the Czech Republic. At its July 2007 meeting, the Division of Licensing granted recognition to Jagiellonian University's English-language programs in Krakow, Poland. Dr. Simon also served as the Board's Medical Consultant for these six reviews.

Attachments

(UCSD) for review. Dr. Simon is an expert medical education consultant and professor at the UCSD School of Medicine, Division of International Health and Cross-Cultural Medicine. Dr. Simon completed a comprehensive evaluation of the institution's Self Assessment Report and supporting data. Dr. Simon's June 11, 2008 report outlining his findings and recommendations is attached for your review. Institution officials addressed all questions and requests for additional information satisfactorily. Dr. Simon recommends that the Board grant recognition to Lublin's English programs with full retroactivity to prior students and graduates.

FISCAL CONSIDERATIONS:

There is no fiscal impact on the Medical Board of California to granting recognition to the Medical University of Lublin's English Program. If the Board grants recognition to the school's English program, graduates of the program will apply for licensure in California. The application processing fees that they remit will defray the costs of reviewing their applications.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

Since 2002, the Board's Division of Licensing has granted the same recognition to six English-language programs offered by existing native-language programs in Europe, including all four Hungarian medical schools and Charles University First Faculty of Medicine in the Czech Republic. At its July 2007 meeting, the Division of Licensing granted recognition to Jagiellonian University's English-language programs in Krakow, Poland. Dr. Simon also served as the Board's Medical Consultant for these six reviews.

Attachments

CALIFORNIA BUSINESS & PROFESSIONS CODE

2089. (a) Each applicant for a physician's and surgeon's certificate shall show by official transcript or other official evidence satisfactory to the Division of Licensing that he or she has successfully completed a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction, in a medical school or schools located in the United States or Canada approved by the division, or in a medical school or schools located outside the United States or Canada which otherwise meets the requirements of this section. The total number of hours of all courses shall consist of a minimum of 4,000 hours. At least 80 percent of actual attendance shall be required. If an applicant has matriculated in more than one medical school, the applicant must have matriculated in the medical school awarding the degree of doctor of medicine or its equivalent for at least the last full academic year of medical education received prior to the granting of the degree.

(b) The curriculum for all applicants shall provide for adequate instruction in the following subjects:

Alcoholism and other chemical substance dependency, detection and treatment.
Anatomy, including embryology, histology, and neuroanatomy.
Anesthesia.
Biochemistry.
Child abuse detection and treatment.
Dermatology.
Geriatric medicine.
Human sexuality.
Medicine, including pediatrics.
Neurology.
Obstetrics and gynecology.
Ophthalmology.
Otolaryngology.
Pain management and end-of-life care.
Pathology, bacteriology, and immunology.
Pharmacology.
Physical medicine.
Physiology.
Preventive medicine, including nutrition.
Psychiatry.
Radiology, including radiation safety.
Spousal or partner abuse detection and treatment.
Surgery, including orthopedic surgery.
Therapeutics.
Tropical medicine.
Urology.

(c) The requirement that an applicant successfully complete a medical curriculum that provides instruction in pain management and end-of-life care shall only apply to a person entering medical school on or after June 1, 2000.

Clinical Instruction

2089.5. (a) Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.

(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.

(d) Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:

(1) Is a formal part of the medical school or school of osteopathic medicine.

(2) Has an approved residency program in family practice or in the clinical area of the instruction for which credit is being sought.

(3) Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.

(4) Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.

(e) If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:

(1) The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.

(2) The school and hospital shall provide to the division a description of the clinical program. The description shall be in sufficient detail to enable the division to determine whether or not the program provides students an adequate medical education. The division shall approve the program if it determines that the program provides an adequate medical education. If the division does not approve the program, it shall provide its reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.

(3) The hospital, if located in the United States, shall be accredited by the Joint Commission on Accreditation of Hospitals, and if located in another country, shall be accredited in accordance with the law of that country.

(4) The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.

(5) The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.

(6) The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.

(7) The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.

(8) The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.

(9) The division, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the clinical program, if the division has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.

(10) The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the division or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

TITLE 16. PROFESSIONAL AND VOCATIONAL REGULATIONS

DIVISION 13. MEDICAL BOARD OF CALIFORNIA

CHAPTER 1. DIVISION OF LICENSING

ARTICLE 4. SCHOOLS AND COLLEGES OF MEDICINE

This database is current through 01/06/2006, Register 2006, No. 01.

Section 1314.1. International Medical Schools.

(a) For purposes of Article 5 of Chapter 5 of Division 2 of the code (commencing with Section 2100), a medical school's resident course of instruction that leads to an M.D. degree shall be deemed equivalent to that required by Sections 2089 and 2089.5 of the code if the medical school offers the curriculum and clinical instruction described in those sections and meets one of the following:

(1) The medical school is owned and operated by the government of the country in which it is located, the country is a member of the Organization for Economic Cooperation and Development, and medical school's primary purpose is educating its own citizens to practice medicine in that country; or

(2) the medical school is chartered by the jurisdiction in which it is domiciled and meets the standards set forth in subsection (b) below.

(b)(1) Mission and Objectives.

The institution shall have a clearly stated written purpose or mission statement and objectives that include:

(A) The institution's broad expectations concerning the education students will receive;

(B) The role of research as an integral component of its mission, including the importance, nature, objectives, processes and evaluation of research in medical education and practice; and

(C) Teaching, patient care, and service to the community.

The institution shall have institutional objectives that are consistent with preparing graduates to provide competent medical care.

(2) Organization.

The institution shall be organized as a definable academic unit responsible for a resident educational program that leads to the M.D. degree. The manner in which the institution is organized shall be set forth in writing.

(3) Curriculum.

The structure and content of the educational program shall provide an adequate foundation in the basic and clinical sciences and shall enable students to learn the fundamental principles of medicine, to acquire critical judgment skills, and to use those principles and skills to provide competent medical care.

(4) Governance.

The administrative and governance system shall allow the institution to accomplish its objectives (i.e. its statements of the items of knowledge, skills, behavior and attitude that students are expected to learn). An institution's governance shall give faculty a formal role in the institution's decision-making process. A student enrolled in the program shall not serve as an instructor, administrator, officer or director of the school.

(5) Faculty.

The faculty shall be qualified and sufficient in number to achieve the objectives of the institution. A "qualified" faculty member is a person who possesses either a credential generally recognized in the field of instruction or a degree, professional license, or credential at least equivalent to the level of instruction being taught or evaluated. The institution shall have a formal ongoing faculty development process that will enable it to fulfill its mission and objectives.

(6) Admission and promotion standards.

The institution shall have and adhere to standards governing admission requirements and student selection and promotion that are consistent with the institution's mission and objectives.

(7) Financial Resources.

The institution shall possess sufficient financial resources to accomplish its mission and objectives.

(8) Facilities.

The institution shall have, or have access to, facilities, laboratories, equipment and library resources that are sufficient to support the educational programs offered by the institution and to enable it to fulfill its mission and objectives. If an institution utilizes affiliated institutions to provide clinical instruction, the institution shall be fully responsible for the conduct and quality of the educational program at those affiliated institutions.

(9) Quality Assurance System.

If the institution provides patient care, it shall have a formal system of quality assurance for its patient care program.

(10) Records.

The institution shall maintain and make available for inspection any records that relate to the institution's compliance with this section for at least five years, except, however, that student transcripts shall be retained indefinitely.

(11) Branch Campuses.

An institution with more than one campus shall have written policies and procedures governing the division and sharing of administrative and teaching responsibilities between the central administration and faculty, and the administration and faculty at the other locations. These policies shall be consistent with the institution's mission and objectives. The institution shall be fully responsible for the conduct and quality of the educational program at these sites. If an institution operates a branch campus located within the United States or Canada, instruction received at that branch campus shall be deemed to be instruction received and evaluated at that institution. For purposes of this section, the term "branch campus" means a site other than the main location of the institution but does not include any hospital at which only clinical instruction is provided.

(c) The division may, on its own or at the request of an institution, determine whether that institution meets the requirements of subsections (a) and (b). The division shall have the sole discretion to determine whether a site visit is necessary in order to verify the accuracy and completeness of the data provided and to conduct an in-depth review of the program to determine whether the institution is in compliance with this regulation.

(d) An institution's failure to provide requested data regarding its educational program or to cooperate with a site team shall be grounds for disapproval of its educational program.

(e) If the division determines that a site visit is necessary, it shall appoint a site inspection team to conduct a comprehensive, qualitative onsite inspection and review of all aspects of the institution's operations to determine whether the institution complies with the requirements of subsections (a) and (b).

The fee for a site visit is all reasonable costs incurred by the board staff and the site team, payable in estimated form in advance of the site visit. If the cost of the site visit exceeds the amount previously paid, the board shall bill the institution for the remaining amount and shall not take action to determine the institution's equivalency until such time as the full amount has been paid. If the amount paid exceeds the actual costs incurred, the board shall remit the difference to the institution within 60 days.

The site team shall prepare and submit to the division a report that includes

(1) Its findings regarding the institution's compliance with the requirements of the law and this regulation;

(2) Its assessment of the quality of the institution as a whole and the quality of the institution's educational program, including any deficiencies; and

(3) Its recommendation whether or not the institution's resident course of instruction leading to an M.D. degree should be deemed equivalent to that required by Sections 2089 and 2089.5 of the code, including a recommendation regarding the correction of any deficiencies identified in the report. A copy of the report shall be provided to the institution, which shall have60 days following the date of the report in which to respond to board staff as to any errors of fact or erroneous findings.

(f) If an institution wishes to retain the division's determination that its resident course of instruction leading to an M.D. degree is equivalent to that required by Sections 2089 and 2089.5 of the code, or if it is currently being evaluated for such equivalency, it shall do the following:

(1) It shall notify the division in writing no later than 30 days after making any change in the following:

(A) Location;

(B) Mission, purposes or objectives;

(C) Change of name;

(D) Any change in curriculum or other circumstance that would affect the institution's compliance with subsections (a) and (b).

(E) Shift or change in control. A "shift or change in control" means any change in the power or authority to manage, direct or influence the conduct, policies, and affairs of the institution from one person or group of people to another person or group of people, but does not include the replacement of an individual administrator with another natural person if the owner does not transfer any interest in, or relinquish any control of, the institution to that person.

(2) Every seven years, it shall submit documentation sufficient to establish that it remains in compliance with the requirements of this section and of Sections 2089 and 2089.5 of the code.

(g) The documentation submitted pursuant to subsection (f)(2) shall be reviewed by the division or its designee to determine whether the institution remains in compliance with the requirements of these regulations and of Sections 2089 and 2089.5 of the code.

(h) The division may at any time withdraw its determination of equivalence when an institution is no longer in compliance with this section. Prior to withdrawing its determination of equivalence,

the division shall send the institution a written notice of its intent to withdraw its determination of equivalence, identifying those deficiencies upon which it is proposing to base the withdrawal and giving the institution 120 days from the date of the notice within which to respond to the notice. The division shall have the sole discretion to determine whether a site visit is necessary in order to ascertain the institution's compliance with this section. The division shall notify the institution in writing of its decision and the basis for that decision.

(i) The division may evaluate any institution described in subsection (a)(1) to determine its continued compliance with Sections 2089 and 2089.5 of the code if, in its sole discretion, the division has reason to believe that the institution may no longer be in compliance.

DIVISION 13. MEDICAL BOARD OF CALIFORNIA

For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.

General Materials (GM) - References, Annotations, or Tables

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2018, 2089, 2089.5, 2102 and 2103, Business and Professions Code.

HISTORY

1. New section filed 11-13-2003; operative 12-13-2003 (Register 2003, No. 46).

UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

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DIVISION OF INTERNATIONAL HEALTH AND
CROSS CULTURAL MEDICINE

9500 GILMAN DRIVE
LA JOLLA, CALIFORNIA 92093-0622

Attn: Ms Stacie Berumen, Manager Date: June 11, 2008

From: Harold J. Simon, M.D., Ph.D., FACP, Medical Consultant

Subject: **Recognition of International Medical School Program**
Medical University of Lublin (English Program) (MUL-ELD) – Lublin, Poland

The Division has requested a review of the **MUL -ELD's** Self Assessment Report **(Report)** submitted in pursuit of an application for recognition of the **MUL -ELD** by the Division of Licensing (DOL) to enable students at and graduates of **MUL** to participate in clinical clerkships and graduate clinical training programs in California and – provided all other requirements have been satisfied – to become eligible for licensure to practice medicine in this State. The ensuing narrative is based on study and analysis of this **Report**.

INTRODUCTION AND OVERVIEW

Documentation about the institution's Statement of Objectives and Mission, Charter, Organization and Governance is provided in the **Report** and fulfills the DOL's requirements in these dimensions.

MUL is chartered, operated by and under the aegis of the Polish Government through the Ministries of Health and of Science and Higher Education. The **ELD** is administered within **MUL** under the direction of MUL'S central administration.

Note: This Review and Analysis is based entirely on the materials contained in the **Report**. No other sources of information on **MUL** were available to this reviewer.

Poland is a Member of the Organization for Economic Cooperation and Development (OECD) and the European Union (EU) .

MUL's primary purpose is to educate its own citizens to practice medicine in Poland.

The **MUL's** professional degrees have long been recognized by Poland, and its graduates have been permitted to practice in numerous countries of Europe, Asia and North America.

Graduates of the **ELD** are eligible to practice in Poland after satisfying all the **MUL's** requirements. US students are eligible to take the USMLE.

All **MUL's** programs require approval by the Faculty Council, and are further subject to approval by the Ministries of Health and of Science and Higher Education.

MUL is situated in Lublin, a large city located in Western Poland near the Eastern Boundary of the European Union. It embodies 5 universities with 80,000 students.

MUL was established in 1949, is comprised of >100 departments and clinics and offers programs leading to the BSc, MA, MD and Ph.D. degrees.

MUL embodies

The First Faculty of Medicine and Dentistry Division;
The Second Faculty of Medicine with the **ELD;**
The Faculty of Pharmacy with the Medical Analysis Division; and
The Faculty of Nursing and Health Sciences.

Note: MUL is a free-standing institution and not part of a larger university.

FACILITIES:

MUL embodies 11 new and old buildings. Seven buildings house lecture halls, offices, student and faculty research laboratories and libraries. There are 3 hospitals and clinic buildings and an athletic facility.

The **main library's** holdings include 130,535 books; 40,033 journals which include 431 Polish titles; 158 Foreign titles; and access to Polish and International data bases.

These facilities appear adequately equipped and eminently sufficient for the stated purposes.

There is an A/V facility but no special facilities for illustration, photography, electronics or computer/data processing, nor is there a machine shop.

According to a newspaper's ranking, **MUL** is accorded 5th place among the 11 Polish medical universities. In 2007, the Polish Parliament saw fit to amend the institution's title "Academy" to "University."

CURRICULUM

Note: The entire curriculum was last reviewed in 2005 by the Polish State Accrediting Agency (PKA) and found to conform completely to the requirements and standards established in 1993 by the **Association of European Medical Schools.** Consequently, accreditation was extended for the next 5 years.

Admission requirements are identical with those for the mainstream program. Instruction in the Polish Language throughout the first two years is the principal difference between the mainstream (Polish) and **ELD** curriculae which are otherwise identical. All preclinical science courses include practical exercises conducted in well-equipped student laboratories.

The 6-year curriculum of the **ELD** is divided among three main categories: basic education in premedical sciences (1st and 2nd years); pre-clinical subjects and introduction to clinical clerkships (3rd and 4th years); basic clinical clerkships (5th year); and a year for "internships" comparable to advanced clinical clerkships and subinternships in the U.S. Some of these may be taken in affiliated hospitals in other countries.

The 4-year* medical curriculum is identical with the 6-year* program but omits the pre-medical 2 years. It includes >5,500 didactic, laboratory-based and clinical hours. Both programs include instruction in the Polish Language in the first 2 years.

*__Note:__ the term "final year" will be used henceforth in place of 4th or 6th year, respectively, and as appropriate.

The aims and objectives of the individual courses are described *in extenso*. Both programs conform completely to the stipulations specified in **Section 2089** of the California Business & Professions Code. Insofar as the stipulations in **Section 2089.5** are concerned, the documentation provided regarding the affiliated hospitals currently being used in the United States conform to the requirements of statute.

Instruction in the pre-medical and pre-clinical years of the **ELD** is in English utilizing standard American and British texts. The Polish Language courses are augmented by specially prepared materials addressing matters pertaining to obtaining and conducting the medical history, physical examination, and psycho-social factors in physician-patient relationships and interactions in accord with Polish culture and customs.

ELD students must demonstrate proficiency in Polish before they begin clinical training by passing a final examination in the Polish language at the end of four semesters. During the students' clinical training, English-speaking clinicians also assist students to enhance communication with patients.

Instruction proceeds in parallel with the mainstream (Polish) curriculum in terms of topic coverage and duration. Moreover, since all ICM and clinical activities involving patients require competency in the Polish language, intensive instruction in Polish is integral within the **ELD** curriculum for the first 2 years.

The last 2 years are taught chiefly in Polish.

On petition, a limited number of leaves of absence may be granted for students to pursue approved, specialized courses elsewhere and/or to prepare for and/or sit for specific diploma or other examinations (e.g., USMLE).

The specifics of the curriculum are described in exhaustive detail by department and lecture/laboratory/practical/study topic on a credit hour basis. Examination policies and practices are also described in detail, together with a schedule of course-by-course examinations. A summary follows:

Attendance at every class is strongly recommended and monitored.

Attendance at and participation in laboratory/practical exercises and seminars is mandatory and enforced by requiring students to have attendance records signed at every occasion.

If such a class/exercise is missed, a valid excuse must be submitted. Makeups may be permitted through attendance at another student group. A student faces disciplinary if s/he misses more than 2 such sessions.

In addition to instruction in some pre-medical topics and the usual pre-clinical sciences, the academic program for the 1st **year** of the **6-year medical curriculum** includes required courses in first aid and resuscitation, medical psychology, and the Polish language.

Instruction in the pre-medical sciences is continued in the 2nd year supplemented with continuing instruction in the Polish language.

The bulk of the **3rd year (1st year of the 4 year program)** is devoted to pre-clinical courses, introduction to the clinical disciplines (ICM) , and medical sociology. Students study and participate in exercises addressing introduction to the hospital, its organization and diverse functions, interactions among the various professional and supporting personnel, and approaches to and interactions with patients. They also learn to perform diagnostic and therapeutic procedures.

The **4th year (2nd year of the 4 year program)** continues to address pre-clinical topics such as pharmacology, therapeutics, and introduction to the basic clinical clerkships again taught almost exclusively at **MUL.**

Every student's progress is monitored and closely evaluated in each course in accord with a 5-point grading scale. Evaluation is based upon performance on written, oral and practical examinations. The examinations are followed by obligatory practicals in laboratory and/or hospital settings, as appropriate.

Strict adherence is required to each and every element of student evaluation: Attendance (with sign-ins and maintenance of log books), dates and times for taking examinations, etc.

Note: Most instruction in ICM and the basic clinical clerkships in Years 3-4 takes place entirely in the University teaching hospitals and clinics located in Lublin.

The **5th year (3rd year of the 4 year program)** covers the basic clinical clerkships which include internal medicine, surgery, pediatrics, Ob/Gyn, neurology, and psychiatry plus topics in epidemiology, forensics, family medicine, emergency medicine, and bioethics.

The 6th and final year (4th year of the 4 year program) embodies advanced and specialty clinical clerkships which correspond to advanced clerkships and subinternships in the US. These clerkships may be pursued at **MUL**, in Polish regional hospitals, or in teaching hospitals abroad (often in students' home countries) when recognized as appropriate teaching institutions by the **MUL** administration. Off-site teaching hospitals are said to be reviewed every 5 years by the Dean and his associates.

Students pursuing clerkships outside Poland must submit detailed reports of their work and conditions at the host institution.

The **Report** identifies the locations where final year students may pursue advanced clinical clerkships elsewhere in Poland, at 21 sites in 20 other European countries and the US. Although the **Report** refers to affiliations in India and the UK information, **MUL** does not have any affiliations with any teaching hospitals in India or the UK at this time. There are no plans for opening any training sites in the UK or India.

The **Report** addresses the duties and responsibilities of the partners, the activities to be conducted at these hospitals, and financial considerations. Copies of documents utilized for site visits to assess conditions and educational activities at affiliated hospitals are also provided in the **Report**.

Note: The **Report** states that final year clerkships at affiliated hospitals in the US exist only at ACGME/LCME approved facilities.

Note: The **Report** indicates that **MUL-ELD** has formal (written) affiliation agreements for clinical instruction with all hospitals utilized for teaching abroad and that all of these are affiliated with medical schools. Documentation provided on the affiliated US hospitals clarified the hospitals' medical school affiliations.

MUL confirmed that residency training programs exist in these institutions in the clinical disciplines in which the clerkships are conducted or the institutions otherwise satisfy the requirements in Section 2089.5. **MUL** identified which hospitals also train students from other medical schools in these hospitals. **MUL**'s Dean is committed to assisting students who plan to qualify for licensure in California by ensuring that they are assigned to train in hospitals that will satisfy the current and future requirements in California statute.

For monitoring the final year clinical clerkships in North America, **MUL** utilizes the Director of Medical Education at Hope Medical Institute (HMI). **MUL** provided the Curriculum Vitae of the site visitors who monitor these clinical training facilities.

The Dean of the **ELD** and a faculty member visit off-campus training facilities to assess compliance with **MUL** standards. Currently site visits are conducted annually by designated members of the Dean's Office. Under a newer protocol, site visits will be conducted yearly or more frequently, if needed.

Several site visit reports were provided for the Board's review. This reviewer noted that the report format solicited data in a more qualitative rather than quantitative approach. For example, the form asks if the bed census was adequate rather than requesting the bed census. The Dean accepted this reviewer's suggestion to revise the form to add quantitative data.

Before graduation, students are required to write a "thesis." Their choice must be approved by the relevant department. The completed work is submitted as an integral part of the final examination before the diploma/degree is awarded.

With mandatory fulfillment of these requirements, as is the case for all components and requirements of the mainstream medical education program, the **ELD** curriculum is initially identical with and proceeds in parallel with the mainstream medical curriculum. It is eventually completely integrated into the mainstream program.

Before receiving a diploma, students enrolled in the **ELD** must have satisfied all the requirements set forth by **MUL** and in accord with the Ministries of Health and of Science and Education and the EU. This includes all requirements that pertain to the mainstream curriculum, including mid-term, semi-final and final examinations in the individual courses and clerkships plus submission of the "thesis." They must also adhere to the established schedules, sign in to classes, maintain log books, and conform to every other requirement.

The **final year** concludes with final written, oral and practical examinations in the major clinical disciplines.

ELD students are not required to pass a national examination in Poland before a diploma is awarded. **ELD** graduates who wish to practice medicine in Poland would need to pass a national examination and complete a 13-month internship in Poland.

All faculty are required to schedule office hours so that students may request advice, discuss academic problems, and receive additional information from professors. They may also

consult the Vice-Dean of the **ELD** directly and, for complex issues or to appeal a decision of the Vice-Dean, to consult the Vice-Rector for Education.

Note: The **Report** describes a self-directed "independent study process under a tutor." This process provides for some individualizing of the curriculum in accord with a student's own proclivities and interests while at the same time not omitting any of the standard courses, examinations, and required attendance at laboratory exercises.

US students in the **ELD** may take Step I of the USMLE after completion of the pre-clinical curriculum. Taking/passing the USMLE is neither required nor monitored. However, **MUL** plans to implement USMLE-type testing as part of the curriculum to assist students to become acquainted with USMLE-type questions during their basic science courses.

MUL offers only a partial record of the **ELD**'s students taking/passing the USMLE. Thus: Between 2002 and 2007, 50 students took Step 1 and 41 passed on the first try. **MUL** officials do not know the fate of the nine students who failed Step 1 on their first attempt.

Between 2002 and 2007, 7 students took and passed Step 2 on the first try. In the future, students being accepted into **MUL** will sign an agreement requiring them to forward their USMLE scores to the university for inclusion in the school's databank. **MUL** states that they have initiated a program to require students to submit their USMLE scores to the administration.

Note: Students enrolled in the **ELD** are not permitted to serve as instructors, administrators, officers, or directors of the University.

RESEARCH AT MUL:

Students learn how research is conducted through targeted instruction, participating in a broad range of faculty research activities, and working on student-generated projects organized within the Students Research Association under supervision of the Vice-Rector for Science. They design and participate in research projects which, if they involve clinical work, must be approved by the Bioethical Committee and must meet the ethical and scientific requirements imposed by Polish/EU and international law. If appropriate, they may obtain support from funds specifically designated for student projects, participate in conferences and poster sessions, and have results of their work published.

Before graduating, students in the **ELD** have to conduct a "draft" research project under supervision of a professor and present their results in writing. These are discussed and analyzed by the course coordinator and classmates.

Support for research at **MUL** in 2006 amounted to about US$7 million (US$1.00 = Polish Zloty 2.00 (approximately)) with US$15,OOO available for student projects and travel to scientific meetings.

Upon first review, this seemed a very small amount of research grant support for faculty and almost impossibly small for students, all of whom are supposed to complete a research project prior to graduation. However, the Dean clarified that the sums identified are those available for student travel to scientific meetings. Support for the projects themselves comes through their preceptors/supervisors.

An extensive listing of faculty and student clinical and laboratory-based research projects and the responsible faculty is provided in the **Report** as is a comprehensive list of laboratories and equipment to support projects. A list of publications shows that the great majority are in Polish journals.

STUDENTS

A total of 5,500 students are currently enrolled in all **MUL** programs of whom 2,200 are medical students.

The **ELD** was added to the existing MUL programs in 1995 as a 4-year program for students who had attended college. Three students enrolled in the first class. In 1999, a 6-year program was added for students straight out of high school. Currently, 338 students are enrolled in the **ELD.**

By 2006, **MUL** had graduated 110 students from the **ELD** program.

Initially, **MUL** responded that the school is not obligated to maintain records of where the graduates of the **ELD** have entered residency training programs. Subsequently, **MUL** provided a list of 52 residency training placements secured by graduates of the **ELD** program in U.S. teaching hospitals, mostly in primary care specialties. A system is now in place to collect information on their graduates' success in obtaining residency training positions and licensure. **MUL**'s U.S. affiliate, Hope Medical Institute, has created a position of Director of Alumni Affairs to maintain and update this information for inclusion in an extensive databank.

In 2004, the **ELD** was enlarged to include other international students with preference given to applicants from countries in North America and Europe. Later, the **ELD's** mission was further broadened to include students from countries which have a physician shortage. Entering enrollment in the ELD for 2007-08 is estimated at > 70.

MUL also offers programs leading to the Ph.D. degree in basic and clinical biomedical sciences. These are available to "outstanding" students in the **ELD** after completion of that program's requirements.

Students are admitted after completion of college or high school (which, in Europe, includes the US equivalent of the first 2 years of college). (See below) .

There is an Academic Office for Career Development which provides students with personal, professional and career advice, a data base of potential employers and job catalogues.

The majority of students are said to be very pleased with their teaching/learning experiences at **MUL,** residency placements at prestigious institutions, and licensure in many countries. Although **MUL** has not routinely tracked residency placements in US hospitals or licensure, sample data to support this statement was provided to this reviewer, and, as stated above, **MUL** has created a position of Director of Alumni Affairs who will oversee the process of compiling the data into a database.

ADMISSION TO AND PROMOTION IN THE ELD

All applicants for admission to the **ELD** are required to have completed high school and possess certification to that effect. Minimum requirements for eligibility for the **6-year program** include

*A completed application with attached current passport size photo;
*Birth certificate;
*Copy of Passport ID page;
*High school transcript(s);
*Minimum of a one-page essay about I want to become a physician.
*SAT score (if SAT was taken);
*Two letters of recommendation (one from an academic and one from a non-academic institution (employer) or where applicant did volunteer work; and
*Completion of a health assessment form.

Minimum requirements of applicants for the **4-year** include all of the above plus official copies of MCAT score (if exam taken); college transcripts; and college diploma/degree.

Note: There does not appear to be an entrance exam in the basic sciences for either the 6-year or the 4-year program to assess adequacy of preparation. Neither SAT nor MCAT are required to apply to the ELD. When this reviewer inquired into this issue, the Dean responded that their preliminary data indicate that applicants to the 6-year program with a GPA above 3.3 and Advanced Placement classes in the sciences perform best in the program. Applicants to the 4-year program with a college degree and a concentration of advanced-level sciences courses perform best in the program.

On **MUL's** receiving an application for admission, the file is assessed for completeness. A detailed analysis is conducted to assess the student's level of exposure and depth of knowledge in diverse medical/scientific courses, extracurricular activities and professional experience in science, if any.

Preference is given to international applicants with a science background, research orientation, evidence of self-discipline and ethical behavior. After a preliminary decision is reached to consider admission, applicants are interviewed by the **MUL** Admissions Committee to assess the presence of these factors. After a final decision is reached to admit the student, s/he matriculates after taking and signing an oath which confirms adherence to the MUL's mission and objectives. The admission decisions are made by an Admissions Committee headed by the Vice-Rector for Education.

Data on applicants' average GPAs are not to hand.

MUL provided its criteria for accepting transfer students in advanced standing. These admissions criteria were largely sound, and acceptance of such transfer students is not common practice. **MUL** has not accepted any transfer students from medical schools that the Medical Board of California has disapproved. The maximum allowable credit that students may transfer from another school is two years. **MUL** will not accept course work completed outside a medical school or course work completed on the Internet or in a school that requires little time spent in the classroom and laboratories.

FACULTY

The **MUL Faculty** consists of a comprehensive, apparently competent and well-organized teaching faculty which conducts a logically ordered, comprehensive medical educational program along traditional European lines. All faculty are required to

Educate students;
Conduct scientific research;
Participate in the organization of **MUL**; and
Upgrade their own qualifications.

More highly qualified faculty are also required to participate in the education of scientific staff.

The Faculty of Medicine numbered 628 in 2005 of whom 92 were professors, 83 were assistant professors and the remainder were Ph.D.s. The total was 646 in 2007-2008. (The numbers provided do not quite match up). Among the faculty

*The great majority are holders of both M.D. and Ph.D. degrees;
*Most have been employed at **MUL** for >20 years; and

*They are evaluated periodically by students, peers and by the Administration in accord with their teaching, research activities, publications, supervising of students, attendance at national and international congresses, conferences and scientific symposia, honors and prizes received, extramural financial support, administrative and senate activities, etc.

All are established medical educators. All are said to be full-time. Faculty members participate in research and publish findings in both national and internationally recognized journals.

Furthermore, the **Report** states that the physician faculty does not carry out much research because they practice their professions in the University Hospitals and Clinics. Overall research productivity seems relatively meager, considering the size of the faculty. When this reviewer inquired, **MUL** clarified that clinical faculty are required to devote at least 50% of their time to their clinical responsibilities. Faculty are permitted to pursue private practice that is compensated separately from their **MUL** salary, but they must obtain written permission from the Rector.

No information is provided about the **ELD's** faculty's bi-or multi-lingual competence in the pre-medical, pre-clinical or clinical years. In the clinical years, lectures, seminars, rounds and case presentations may be held in English or Polish.

Faculty teaching in the **ELD** receive additional compensation for their teaching services from the tuition and fees paid by students in the ELD program.

FINANCIAL MATTERS

All activities at **MUL** are said to be financed by the Polish Government through the Ministries of Health and of Science and Education.

Based on the detailed breakdown provided, the **ELD** is is fully funded through student tuition and fees. Revenues collected from tuition and fees from **ELD** students in 2007 totaled 6,667,232 zlotys (or approximately U.S. $3,157.990.95).

An extraordinarily detailed set of documents covering **MUL**'s financial situation and the budget for 2007 is included in the **Report** together with copies of detailed Reports from both governmental and independent auditors.

Tuition is free for native students admitted into the mainstream program. For students enrolled in the **ELD,** which also includes Polish citizens:

In the ELD, tuition and other costs amount to
*US $33,176 for the Basic Science Years;
*US $31,586 for the Clinical Years (Polish students);
*US $47,250 for the Clinical Years (US students); and
*A one-time US$500 Registration fee.

*The above cost differential depends on whether students take advanced clinical clerkships in Poland or in the US.

*These amounts do not include costs of room, board and other living expenses which may be conservatively estimated at about US $500/month.

FUTURE PLANS

A detailed set of plans and proposals for the future is supplied in response to the Questionnaire. These largely consist of a long list of hopes and wishes for expansion and modernization of existing activities and facilities as well as a much greater emphasis on IT throughout.

The document suggests that many of these plans will likely not be achievable with the current faculty. However, the **MUL-ELD** employs relatively young and very well-qualified teachers. The Dean believes that the faculty is adequate to achieve future goals. We can wish **MUL** every success in these endeavors.

Funds to support any conversion of these plans and proposals into reality do not yet seem to be to hand. Efforts are to be made to increase financial support through patient-care programs and solicitation of funds from national, international and private sources. For example, **MUL** secured $40,000,000 to construct a new pharmacy college and physiotherapy center.

RECOMMENDATIONS:

This reviewer suggests that approval be recommended for final year students in the **MUL-ELD** to participate in clerkships in California and for graduates to participate in residency training and to become eligible for licensure to practice medicine in the State of California, subject to the following stipulations:

For final year medical students to be eligible to pursue clinical clerkships in California, documentation should be required that they are proficient in English, have satisfied all of the **ELD**'s requirements, are in good academic standing, and have passed the USMLE Step 1.

For graduates of the **MUL-ELD** to be eligible to pursue residencies in California, the same requirements should apply as for final year students with the additional stipulations that they shall have received the Diploma or M.D. degree, have passed Steps 1 and 2 of the USMLE, the Clinical Skills Assessment examination, and the ECFMG examination, as may be indicated.

To become eligible for licensure, applicants from **MUL-ELD** should be required to satisfy all the above plus having passed Step 3 of the USMLE as well as satisfying all additional statutory requirements (e.g., two years of residency training) as well as those applicable to US and Canadian applicants.

A condition for recognition of the **MUL-ELD** might stipulate periodic reviews of this program at 7-year intervals, as is authorized in subsection (f)(2) of section 1314.1, Title 16, CCR. (Perhaps one site visit for all Board-recognized Hungarian, Czech and Polish English Language Programs might be considered.)

As another condition for recognition, it may be desirable to ask **MUL-ELD** to provide periodic (annual or biennial?) reports of the information obtained from the various data bases on their students' USMLE performance and on their graduates' experiences vis-à-vis residencies and licensure.

In consideration of the above, and when **MUL** is finally recognized by the Board, this reviewer recommends that recognition be extended retroactively to include all graduates of the **MUL-ELD.**

Respectfully submitted,

Harold J. Simon, M.D., Ph.D., FACP
Consultant

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	May 30, 2008
ATTENTION:	Board Members
DEPARTMENT:	Medical Board of California, Licensing Program
SUBJECT:	Recognition of International Medical School Program Poznan University of Medical Sciences' English Program, Poznan, Poland
STAFF CONTACT:	Deborah Pellegrini, Chief, Licensing Program

REQUESTED ACTION:

Determine if Poznan University of Medical Sciences' English-language program satisfies the minimum requirements of statute and should be granted recognition.

STAFF RECOMMENDATION:

Staff recommends that the Board grant recognition to the Poznan University of Medical Sciences English Program, based on the Medical Consultant's positive findings and recommendations. This would be consistent with the Board's prior decisions regarding European programs of this type.

EXECUTIVE SUMMARY:

The Poznan University of Medical Sciences in Poznan, Poland, founded its Polish-language medical school in 1919. In 1993, the institution began to offer a four-year medical education program for non-citizens using English as the language of instruction. A six-year English-language program was added in 1994 for high school graduates who have not completed the postsecondary pre-medical coursework required to enter medical school.

The Board presently recognizes Poznan University of Medical Sciences' Polish-language medical school whose primary purpose is to educate its own citizens to practice medicine in Poland. In accordance with Title 16, CCR, subsection (c) of section 1314.1, Poznan University of Medical Sciences has requested that its English programs for foreign national students be recognized by the Board. Additionally, subsection (a)(2) of section 1314.1 requires the institution to meet the standards set forth in subsection (b) of section 1314.1. Copies of B&P Code sections 2089 and 2089.5 and Title 16, CCR, section 1314.1 are attached with Agenda Item 7A for your reference.

The institution submitted a Self Assessment Report to the Board on April 3, 2007 and supplemental responses on May 12, 2008. These items were forwarded to our Medical Consultant, James Nuovo, M.D., at the University of California, Davis (UCD) School of Medicine, for review. Dr. Nuovo is an expert medical education consultant. He serves as Associate Dean of Students Affairs and Associate Dean for Graduate Medical Education at UCD School of Medicine. Dr. Nuovo completed a comprehensive evaluation of the institution's Self Assessment Report and supporting data. Dr. Nuovo's report dated May 30, 2008 outlining his findings and recommendations is attached for your review. Institution officials addressed all questions and requests for additional information satisfactorily. Dr. Nuovo recommends that the Board grant recognition to Poznan University of Medical Sciences' English Program with full retroactivity to prior students and graduates.

FISCAL CONSIDERATIONS:

There is no fiscal impact on the Medical Board of California to granting recognition to Poznan University's of Medical Sciences' English Program. If the Board grants recognition to the school's English program, graduates of the program will apply for licensure in California. The application processing fees that they remit will defray the costs of reviewing their applications.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

Over the past six years, the Board's Division of Licensing has granted the same recognition to six English-language programs offered by existing native-language programs in Europe, including all four Hungarian medical schools, Charles University First Faculty of Medicine in the Czech Republic, and Jagiellonian University in Poland.

May 30, 2008

To: Patricia Park, Licensing Program
Medical Board of California
1428 Howe Avenue, Suite 56
Sacramento, CA 95825-3204

From: Jim Nuovo, MD
Professor & Associate Dean of Student Affairs and Graduate Medical Education
UC Davis School of Medicine
4860 Y Street; Suite 2300
Sacramento, CA 95817

Re: Evaluation of Poznan University of Medical Sciences-English Language Program/Self-Assessment Report; Application for Recognition in California

BACKGROUND

The Medical Board of California (Board) requested a review of materials provided by the Poznan University of Medical Sciences' English Language Program (PUMS-ELP), located in Poznan, Poland. These were submitted in pursuit of a request for recognition of PUMS-ELP by the Board to enable their students and graduates to participate in clinical clerkships, to enter graduate medical education programs in California, and to become eligible for licensure to practice medicine.

This report is based on my review of the documents provided to the Medical Board.

I have had the opportunity to review the documents submitted by PUMS-ELP. The goal of this review was to determine if the medical education received at PUMS-ELP meets the requirements of current California statutes and regulations for recognition by the Medical Board of California.

RECOMMENDATIONS

The documents provided indicate that PUMS-ELP is in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1, and provides a resident course of professional instruction equivalent to that required by Section 2089.

Based on the School's compliance with these regulations, I recommend that the Board approve PUMS-ELP's request for recognition.

Note: The English-language division of Poznan University of Medical Sciences was known as Karol Marcinkowski University of Medical Sciences until July 2005.

I do not believe a site inspection is necessary. PUMS-ELP documents provide sufficient detail to indicate that the facilities are adequate to fulfill the educational mission of the Program.

The extensive documentation provided by PUMS-ELP as described in this report justifies full retroactivity to coursework completed by all previous PUMS-ELP students.

REVIEW

Poznan University has been in existence for approximately 80 years. Since 1950 it has graduated 13,283 physicians from its program. It has over 1200 teaching and research faculty. Poznan University added the English Language Division to the existing medical program in 1993 as a four-year program. In 1994, a six-year program was added for students who had not completed premedical education. The documents provided in PUMS-ELP's Self-Assessment Report are well-organized and indicate that this program has an effective mission to educate physicians who are competent and capable of entering the next level of training; specifically, training in a residency program.

The following is a detailed assessment of the School based on the aforementioned regulations and on their responses to the Self Assessment Report and additional concerns posed by this reviewer.

Business and Professions Code Sections 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. The PUMS ELP offers a 4-year and a 6-year medical education program. The total number of hours of courses, 4,477 hours, complies with the 4,000 hour minimum requirement in Section 2089. PUMS requires 90% attendance of its students. This exceeds the statutory requirement for 80% attendance. The School's curriculum includes all of the courses listed in Section 2089 (b).

The school acknowledged that it accepts transfer students from other medical schools. The School provided the following details on the policies and procedures of transfer students such as how students are accepted for transfer, how the School determines the amount of credit for previous training, whether there is a limit on the number of transfer students that can be accepted, and whether the last academic year is at the institution.

"Students applying to transfer to our University are required to provide certified transcripts showing courses completed with grades attained. If considered eligible the applicant is offered one of the three options:

1) Direct transfer to the year following that completed elsewhere;
2) As in 1) but required to attend courses in missing subjects and pass the examinations;
3) Entry to the same year as that attended at previous University.

Finishing the second year and passing USMLE step I is required before transfer to the 4-year M.D. Program."

Business and Professions Code Sections 2089.5

PUMS documented that the English program provides instruction in all of the basic sciences and clinical sciences coursework required in Section 2089. As to the specific clinical sciences requirements in Section 2089.5, PUMS documented that instruction in the clinical courses meets or exceeds the minimum requirements in Section 2089.5. For example, Section 2089.5 requires a minimum of 72 weeks of clinical coursework. PUMS' curriculum provides 78 weeks of clinical coursework.

Students complete the core clinical rotations required in Section 2089.5 in local hospitals affiliated with the medical school. "Rotations in surgery, medicine, pediatrics, obstetrics and gynecology, family medicine and psychiatry are carried out in the six hospitals sponsored by the School and in four hospitals, where some affiliated to the University departments are localized (e.g. infectious diseases or diabetology)."

PUMS is a state university that is part of the national system of education, sciences and healthcare. "The clinical resources of the university include six clinical hospitals, toward which the school acts in the capacity of the founder by virtue of applicable laws." The clinical hospitals "operate as separate entities."

There is a full-time director of medical education and a head of the department for each clinical course. The instructors have full-time faculty appointments and appropriate credentials. There is a Faculty Board that functions as the "supreme legislative body" and includes a Dean, Vice-Deans, Chairpersons, Faculty, Academic Staff, and Student Representatives. There is a detailed description of the means by which the school engages in an ongoing review of the program including documentation of the level and extent of its supervision. There is a detailed description of the evaluation process of each student including sample evaluation forms. Further, the evaluations are done on a regular basis and document the completion of all components of the curriculum.

With respect to the clinical resources required in Section 2089.5 to support students' clinical training, PUMS documented that its five teaching hospitals have 2,216 total beds. "The teaching hospitals are very large medical centers and meet the requirements of having an adequate number of patients for students' exposure and experience."

The School provided additional information on the minimum number of patients seen by each student on a specific clinical rotation. The numbers provided are all adequate to meet the educational mission of the Program.

Clerkship	Minimum number of patients seen by each student on a specific clinical rotation*
Obstetrics/Gynecology	**130**
Pediatrics	**140**
Surgery	**155**
Vascular Surgery	35
General Surgery	45
Gastrosurgery	35
Traumatic Surgery	20
Urology	20
Internal Medicine II	**185**
Endocrinology	30
Gastroenterology	25
Pulmonology	25
Nephrology	15
Rheumatology	15
Cardiology	35
Hematology	25
Diabetology	15
Geriatrics	**20**
Psychiatry	**120**
Family Medicine	**80**

* - this number including patients seen by student in the Clinical Wards and in the Outpatient's Departments.

California Code of Regulations, Title 16, Division 13, Section 1314.1

The medical school is owned and operated by the government of the country where it is located, Poland. Poland has been a member of the Organization for Economic Cooperation and Development since 1996. The medical school's purpose is educating its own citizens to practice medicine in Poland.

The Self-Assessment Report contains an extensive, clearly defined mission statement and educational/research and service objectives.

The report includes the exact language of "broad expectations and clearly lists goals and objectives. The report clearly lists the integral role of research in its mission and includes statements of its importance, nature, objectives, processes, and evaluation or research in the medical education and practice of the school. These objectives include teaching, patient care, and service to the community. There are clearly written institutional objectives that are consistent with the preparation of graduates to provide competent care.

The institution is operated as a definable academic unit responsible for a resident educational program that leads to an MD degree.

The structure and content of the educational program provides an adequate foundation in the basic and clinical sciences and enables students to learn the fundamental principles of medicine, to acquire critical judgment skills, and to use those principles and skills to provide competent medical care.

As required in Section 1314.1, the administration and governance system allows the institution to accomplish its objectives, i.e., its statements of the items of knowledge, skills, behavior and attitude that students are expected to learn. The institution's governance gives faculty a formal role in the institution's decision-making process. Students enrolled in the program are not permitted to serve as an instructor, administrator, officer or director of the school.

PUMS is described as having 1200 faculty; an adequate number for the size of the school. There is a sufficient description of the credentials of the faculty to indicate that they are appropriately qualified to teach their specific curricular content.

There is a clear description of the governing body of PUMS which includes a University Faculty Senate and a description of the faculty evaluation and development programs.

There is a clear description of the admissions criteria, student selection and promotion. The descriptions of these activities are consistent with the institution's mission and objectives.

The University receives financial resources from the government of Poland and the University's capital fund to accomplish its objectives. The available funds are documented in the application and appear sufficient. The institution's consolidated audit report was included as an attachment.

The facilities available to carry out the educational mission, both basic sciences and clinical rotations, are described in the report. They are extensive and adequate to achieve the stated educational goals of the program. As noted, the school uses 6 hospitals for the clinical rotations. There is documentation that the school is fully responsible for the conduct and quality of the educational program at all 6 sites.

The university does not provide patient care directly but through the 6 affiliated hospitals. There is an extensive affiliation agreement included in this packet. The affiliated clinical hospitals sign contracts with the National Health Fund for providing patient care. The Minister of Health along with the National Health Fund is responsible for the system of quality assurance for patient care in these settings.

The school indicates that it is compliant with the requirement to retain student transcripts. Student records are kept for "50 years."

The following table is a description of student status. The table for the 4-year program lists the number of students admitted, dropped out, dismissed, on leave of absence, and graduated. There appears to be a discrepancy between the number admitted and graduated. However, the table requests only the last five years of data. The ELD commenced instruction in 1993.

4-YEAR MD PROGRAM

Academic Year	# of Students Admitted *	# of Students Dropped Out	# of Students Dismissed	# of students on leave of absence	# of students graduated	# of students in U.S. post-graduate training*	# of students in non U.S. post-graduate training
2005/2006	68	5	1	5	-	-	-
2004/2005	55	4	2	6	52 expected	-	-
2003/2004	48	5	3	3	37	-	-
2002/2003	28	2	1	0	25	7	-
2001/2002	43	4	5	6	28	8	1

* Numbers reflect some students who transferred from 6 year program.

6-YEAR MD PROGRAM

Academic Year	# of Students Admitted	# of Students Dropped Out	# of Students Dismissed	# of students on leave of absence	# of students graduated	# of students in U.S. post-graduate training*	# of students in non U.S. post-graduate training
2005/2006	72	11	4	3	-	-	-
2004/2005	69	13	5	5	-	-	-
2003/2004	43	3	4	2	-	-	-
2002/2003	36	6	3	3	24 expect.	-	-
2001/2002	30	3	2	2	23	-	-

*** These data are incomplete as the University is continuing to acquire this information.**

Thank you for the opportunity to review the materials from the Poznan University of Medical Sciences-English Language Program/Self-Assessment Report.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 8, 2008
DEPARTMENT:	Executive Office
SUBJECT:	Proposed Regulations – Reduction in License Fees to Offset Loss of Diversion Program
STAFF CONTACT:	Kevin A. Schunke

REQUESTED ACTION:

Approve a request to modify the proposed regulatory language to allow for an effective date of July 1, 2009. Staff should notice the modified text with a 15-day public comment period. If there are no adverse comments, the Board delegates to the Executive Officer the authority to adopt the regulation.

STAFF RECOMMENDATION:

To allow for the timely implementation of the reduction of the initial and renewal licensing fees through the regulatory process in an amount commensurate with the decrease in spending authority due to the discontinuation of the Board's Diversion Program, staff recommends that the language be amended to allow for a later effective date.

EXECUTIVE SUMMARY:

Section 2435.2 of the Business and Professions Code states that the Board shall reduce license and renewal fees if the Diversion Program is eliminated. At the April 24, 2008, Board meeting, a hearing was held on the proposed regulations to implement Section 2435.2.

The time to finalize the file at the Board and move it forward through the approval process was not adequately estimated. Assuming the file is submitted to the Office of Administrative Law by January 1, 2009 and approved by February 1, 2009, this still allows for the four-month window needed to format changes to the printing and mailing of renewal notices. Further, for accounting purposes, it seems logical that the fee reduction take effect at the beginning of Fiscal Year 09-10, instead of the last month or two of the previous fiscal year. Therefore, staff recommends a modified effective date of July 1, 2009.

FISCAL CONSIDERATIONS:

None. This is a cost-neutral proposal.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

At the April 24, 2008 Board meeting, a hearing was held on the proposed regulations to implement Section 2435.2.

Medical Board of California
Specific Language of Proposed Regulations

Reduction in Initial License Fee and Renewal Fee to Offset Elimination of Diversion Program

MODIFIED TEXT: Additions to the originally proposed language are shown by double underline for new text and deletions to the originally proposed language are shown by a strikeout and single underline.

Amend Section 1351.1 and Section 1352, Title 16, California Code of Regulations to read as follows:

Section 1351.5. Initial License Fee.

~~The initial fee for licensure as a physician and surgeon or for a special faculty permit shall be $600 for licensing periods beginning on or after January 1, 1994.~~ The initial license fee for licensure as a physician or surgeon or for a special faculty permit shall be $805 for licensing periods beginning on or after January 1, 2007. The initial license fee shall be $783 for licensing periods beginning on or after ~~November 1, 2008~~ July 1, 2009.

Note: Authority cited: Sections 125.3, 2018, 2168.4 and 2436, Business and Professions Code. Reference: Sections 125.3, 2168.4 and 2435, Business and Professions Code.

Section 1352. Renewal Fee.

~~The biennial renewal fee for licenses or special faculty permits which expire on or after February 28, 1997 shall be $600.~~ The biennial renewal fee for licenses or special faculty permits which expire on or after January 1, 2007 shall be $805. The biennial renewal fee for licenses or special faculty permits which expire on or after ~~November 1, 2008~~ July 1, 2009 shall be $783.

Note: Authority cited: Sections 125.3, 2018, 2168.4 and 2436, Business and Professions Code. Reference: Sections 125.3, 2168.4 and 2435, Business and Professions Code.

LEGISLATIVE PACKET

AGENDA ITEM #10

2008 LEGISLATION

WILL BE FORWARDED UNDER

SEPARATE COVER

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Board	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption	Date to DCA for Review *	Date to OAL for Review **	Date to Sec. of State***
Oral and Written Arguments	Became effective 6/6/08	7/28/07	9/7/07	11/2/07	11/2/07	2/8/08	4/9/08	5/7/08
Continuing Education Requirements	Staff working to complete the file	11/2/07	12/07/07	2/1/08	3/17/08			
Delegation of Services (on behalf of the Physician Assistant Comm)	Filed with Secretary of State 7/8/08; to become effective 8/7/08	11/2/07	12/07/07	2/1/08	2/1/08	3/13/08	5/23/08	7/8/08
Disciplinary Guidelines	At DCA for review (to Agency on 7/1/08)	2/1/08	2/29/08	4/25/08	4/25/08	6/5/08		
Fee Reduction to Offset Elimination of Diversion Prog.	Modified Text to be considered at July 08 Board meeting.	2/1/08	2/29/08	4/25/08	4/25/08			
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Summer-Fall 2008							

* - DCA is allowed 30 calendar days for review
** - OAL is allowed 30 working days for review
*** - **Regs take effect 30 days after filing with Sec. of State**

Prepared by Kevin A. Schunke
Updated July 8, 2008
For questions, call (916) 263-2368

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 8, 2008
DEPARTMENT:	Executive Office
SUBJECT:	SB 376/2003: Direct Employment of Physicians – Report to the Legislature
STAFF CONTACT:	Kevin A. Schunke

REQUESTED ACTION:

Appoint one or two Board members who will work with staff to finalize a report to the Legislature, which is due by October 1, 2008.

STAFF RECOMMENDATION:

Senate Bill 376 (Chapter 411, Statutes of 2003) was authored by Senator Wesley Chesbro and signed into law by the Governor. Under that law, which took effect on January 1, 2004, the Board was directed to establish a pilot program (pilot) to provide for the direct employment of physicians by qualified district hospitals. The pilot is set to expire on January 1, 2011.

The board shall report to the Legislature not later than October 1, 2008, on the evaluation of the effectiveness of the pilot project in improving access to healthcare in rural and medically underserved areas and the project's impact on consumer protection as it relates to intrusions into the practice of medicine.

Since the next meeting of the full Board will be after the report's due date to the Legislature, staff requests the appointment of one or two Board members to work with staff to finalize the report (draft copy attached) and grant approval of the report on behalf of the Board.

EXECUTIVE SUMMARY:

Attached is a draft version of the report. Staff welcomes input from the full Board and looks forward to fine-tuning the final document with the Board member(s) appointed to assist.

FISCAL CONSIDERATIONS:

None. Creation of the report will accomplished within existing resources.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

While staff has reported to the Board on the progress of the program, no previous action has been required by the Board.

MEDICAL BOARD OF CALIFORNIA
Executive Office

SB 376: Direct Employment of Physicians

DRAFT Report to the Legislature

Executive Summary

The Medical Board of California (Board) is required to submit a report to the Legislature by October 1, 2008, offering an evaluation of a pilot program (pilot) which allowed for the direct employment of physicians by qualified hospital districts. The purpose of the pilot was to improve access to healthcare in rural and medically underserved areas, and the evaluation is to address not only access to care issues, but also the pilot's impact on consumer protection as it relates to intrusions into the practice of medicine.

The pilot was promptly implemented by the Board after the bill was signed by the Governor and operational by the time the provisions of the bill became effective. However, the response from qualified district hospitals was limited to the extent that the Board was hindered in making a full evaluation.

Therefore, the Medical Board believes there may be justification to extend the pilot so that a better evaluation of the direct employment of physicians can be made.

History and Background

In California, the practice of medicine is governed by the Medical Practice Act. Specifically, Business and Professions Code (B&P) Section 2052 states that practicing medicine without a valid license is unlawful. Licenses are issued only to individuals.

Further, B&P Sections 2400, et seq., commonly referred to as the "Corporate Practice of Medicine", generally prohibits corporations or other entities that are not owned by physicians or other allied health professionals from practicing medicine, to ensure that lay persons are not influencing the professional judgment and practice of medicine by physicians.

Today, most states, including California, allow exemptions for some professional medical corporations to employ physicians. For example, California allows physician employees at teaching hospitals, some community clinics, narcotic treatment programs, and certain non-profit organizations.

While some states do not enforce their own statutes which ban the corporate practice of medicine, California is more rigorous than most states in this prohibition and is one of only a few states that prohibits the employment of physicians by hospitals (other states: Colorado, Iowa,

Ohio, and Texas). This concept is not specifically written in law; however, the California Attorney General opined in 1971 that hospitals could not practice medicine and therefore could not employ physicians, even for the purpose of serving in emergency rooms.

The responsibility for licensing physicians and for enforcing California's Corporate Practice of Medicine provisions is within the scope of the Medical Board of California (Board).

Senate Bill 376 (Chapter 411, Statutes of 2003) was authored by Senator Wesley Chesbro and signed into law by the Governor. Under that law, which took effect on January 1, 2004, the Board was directed to establish a pilot to provide for the direct employment of physicians by qualified district hospitals. The pilot is set to expire on January 1, 2011.

This bill was sponsored by the Association of California Healthcare Districts (ACHD) to enable qualified district hospitals to recruit, hire, and employ physicians as full-time paid staff in a rural or underserved community meeting the specified criteria. A goal of the legislation was to improve the ability of district hospitals to attract physicians to rural and underserved communities.

Specific requirements of the SB 376 Pilot

- Provides for the direct employment of a total of 20 physicians in California by qualified district hospitals.
- Limits the total number of physicians and surgeons employed by a qualified district hospital to no more than two at a time.
- A "qualified district hospital" is defined as a hospital that meets all of the following requirements:
    - Is a district hospital organized and governed pursuant to the Local Healthcare District Law.
    - Provides a percentage of care to Medicare, Medi-Cal, and uninsured patients that exceeds 50 percent of patient days.
    - Is located in a county with a total population of less than 750,000. (According to the 2000 Census, the following counties have a population over 750,000; therefore, hospitals in these counties are not eligible to participate in the pilot: Alameda, Contra Costa, Fresno, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Ventura.)
    - Has net losses from operations in fiscal year 2000-01, as reported to the Office of Statewide Health Planning and Development.

- The participating hospital is prohibited from interfering with, controlling, or otherwise directing the physician's professional judgment.

- The medical staff and the elected trustees of the qualified district hospital concur by an affirmative vote of each body that the physician's employment is in the best interest of the communities served by the hospital.

- The physician enters into or renews a written employment contract with the qualified district hospital prior to December 31, 2006, for a term not in excess of four years, and the employment contracts provide for mandatory dispute resolution under the auspices of the Board for disputes directly relating to the physician's clinical practice.

- The qualified district hospital must notify the Board in writing that the hospital plans to enter into a written contract with the physician; the Board must provide written confirmation to the hospital within five working days of receipt of the written notification to the Board.

- The board shall report to the Legislature not later than October 1, 2008, on the evaluation of the effectiveness of the pilot project in improving access to healthcare in rural and medically underserved areas and the project's impact on consumer protection as it relates to intrusions into the practice of medicine.

Legislative Intent of the SB 376 Pilot

In crafting the actual bill language of SB 376, the Legislature added the findings and declarations to support the intent of the bill:

- Due to the large number of uninsured and underinsured Californians, a number of California communities are having great difficulty recruiting and retaining physicians and surgeons.

- In order to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities, many district hospitals have no viable alternative but to directly employ physicians and surgeons in order to provide economic security adequate for a physician and surgeon to relocate and reside in their communities.

- The Legislature intends that a district hospital meeting the conditions set forth in this section be able to employ physicians and surgeons directly, and to charge for their professional services.

- The Legislature reaffirms that Section 2400 provides an increasingly important protection for patients and physicians and surgeons from inappropriate intrusions into the practice of medicine, and further intends that a district hospital not interfere with, control, or otherwise direct a physician and surgeon's professional judgment.

Typical Recruitment Process

[Staff is in the process of contacting the Human Resources Team at the participating hospitals to elucidate on the typical recruitment process used to secure the services of a physician using the traditional contracting process compared to the process used to employ a physician under the SB 376 pilot.]

Evaluation of the Pilot

To evaluate the effectiveness of the pilot in improving access to healthcare in rural and medically underserved areas, and the pilot's impact on consumer protection as it relates to intrusions into the practice of medicine, the Board was directed to report to the Legislature no later than October 1, 2008, on the outcome of the pilot.

While SB 376 was being debated before the Legislature, the Board discussed the potential impact of the bill with the author's office. While recognizing that the limitations of the pilot (a statewide total of 20 participants with no more than two physicians at any one hospital) would make only a small first-step towards increasing access to healthcare, the Board anticipated that all 20 slots soon would be filled. After the Governor signed the bill and the law took effect on January 1, 2004, staff was prepared to promptly process the applications as they were submitted. The Board recognized that in order to have an adequate base of physicians to use in preparing a valid analysis of the pilot, as many as possible of the 20 positions would need to be filled.

Unexpectedly, the first application was not received until six months after the pilot became operational, and that hospital (Chowchilla District Memorial Hospital) elected to hire a physician for only three years instead of the four years allowed by the pilot. Further, during the life of the pilot, only six physicians were hired by five eligible hospitals; the Board was concerned that such a low number would not offer a significant, quantifiable improvement in access to healthcare nor would such a low number offer much information to the Board in preparing a valid and useful analysis of the pilot.

The following chart includes the names of the five participating hospitals and the contract period for each of the six participating physicians:

Name of Hospital:	Physician's Contract Period:
Chowchilla District Memorial Hospital	June 14, 2004 - June 13, 2007
Kaweah Delta Healthcare District	August 16, 2004 - August 15, 2008
John C Fremont Healthcare District	February 1, 2005 - February 1, 2009
Pioneers Memorial Healthcare District	April 15, 2005 - April 14, 2009
Pioneers Memorial Healthcare District	December 15, 2005 - December 14, 2009
Mendocino Coast District Hospital	March 24, 2006 - March 23, 2010

Throughout the life of the pilot, periodic contact was made by the Board's staff with the administrators of the participating hospitals, seeking input on the effectiveness of the pilot. However, the administrators offered limited comments, mainly that they were pleased with the physicians' service to patients and that the pilot had been instrumental in bringing the physicians to work in the hospitals.

During December, 2006, the Board sent letters to the participating physicians and to the administrators of the participating hospitals, asking each to start thinking about the effectiveness of the pilot, with a reminder that input from each was essential to the Board's analysis.

In early-2008, the Board sent letters to the same participants, asking each to define the successes, problems (if any), and overall effectiveness of this pilot for the hospital and on consumer protection. The administrators were asked for input as to how the pilot could be strengthened.

Around the same time, the Board sent letters to the hospital administrators on the list of all ACHD members, whether or not the hospital was eligible to participate in the pilot. If the hospital was eligible, the administrators were queried as to why they did you not participate in the pilot. If the hospital was not eligible, the administrators were asked if they would have participated in the pilot if they had been eligible The letter asked what changes could have been made to improve the pilot and if the pilot would have had an impact on access to care in that area?

(A copy of each of the 2008 outreach letters will be included at the end of this report.)

Despite follow-up faxed requests and phone calls, the response to the Board's letters was limited. Four of the six participating physicians replied and staff conducted a site visit with two of the six participants; and the administrators of only three of the five participating hospitals replied. The following is a summary of the replies; physicians are not listed in any particular order.

Comments Submitted by Participating Physicians

Physician #1: This family practice physician was recruited from out of state, where she worked in a hospital; she moved to California only for the purpose of accepting this offer of employment. While not addressing the benefits or drawbacks of the pilot, this physician indicated that "without the program, it would not have been able for [the hospital] to recruit and retain a physician like me." However, this physician left the position almost two years before the end of the employment period and returned to her home state to accept a position in a different hospital.

Physician #2: This oncologist was working in Northern California for a major healthcare organization, but moved to a location several hours away to accept this offer of employment.

This physician offers specialty care that previously was not available to residents without driving two to four hours, thus saving time and gas money for the patients and allowing them to remain

close to their support community. The physician indicated that this specialty care is difficult to offer as a solo-practitioner in rural areas due to the need for extensive medications, treatments, and equipment, which incur exorbitant start-up fees; however, these are resources that a hospital can more easily provide.

This physician deemed the pilot an unqualified success. Since the pilot is scheduled to sunset, and the employment contract is scheduled to end, this physician indicated the intent to find employment elsewhere.

This physician indicated that a reasonable and stable salary was beneficial to his personal circumstances. However, he stated that he believed the pilot had too many restrictions to be successful in its goals; specifically, each condition which determined that a district hospital was not eligible to participate in the pilot was an impediment to increased health care.

Physician #3: This psychiatrist was working in a neighboring county before accepting this offer of employment; he had been offering his services through a public agency. This physician is one of the few who practices this specialty in the area and offers these services primarily to children and adolescents. Previously, many patients had difficulty getting access to this specialty care.

This physician commented that while many physicians are willing to work in underserved areas, they are looking for employment instead of contracted positions. This physician also commented that since many physicians are already employed by public agencies in California, these employment opportunities should be extended to hospitals.

He continues to see patients at a local mental healthcare clinic and is on the instructional staff at a nearby teaching hospital.

Physician #4: This internist identified himself as being in his late-60s. Having worked in private practice (in the same city as the employing hospital) for over 30 years, he already had a significant patient population but had grown frustrated with the business aspects of the traditional private practice model. Being employed by the hospital allowed him to continue offering healthcare service in the area and, through a special billing arrangement with the hospital, he could provide in-patient care to his original patients.

This physician commented on the benefits offered to him as an employee: less expensive insurance (personal health, dental, and malpractice), the opportunity to participate in a 401k fund, and numerous other retirement benefits.

Further, being employed by the hospital alleviated several items to which he would have been obligated in private practice, such as the costs to lease office space and the need to maintain tail-end insurance coverage.

Physician #5: This internist already was living in the city when he was hired. Before being hired, he was working in a medical group but was considering a move out of the area. However, this program was the catalyst which retained him in the area.

Being hired by the hospital allowed him to concentrate on a specialty in which he previously had worked and enjoyed. His new position with the hospital allowed patients to receive a continuity of care by one physician instead of various physicians rotating through the clinic. But most importantly, the employment of this physician allowed for local health care, instead of having the patients drive several hours for this care, which often had been the only option.

Physician #6: There was no reply to the survey from this physician. However, it was determined that this family practice physician already was living in the city when hired. The employment period has ended and this physician went to work in a local community clinic.

Comments Submitted by Administrators of Participating Hospitals

Chowchilla District Memorial Hospital: There was no reply to the survey from this hospital.

John C. Fremont Healthcare District: There was no formal reply to the survey from this hospital. However, subsequent email communications with hospital staff indicate that within a short period after the physician's departure, the hospital entered into a traditional contract with another physician for services left by the vacancy.

Kaweah Delta Hospital: This administrator pointed out that physicians are employed by many public agencies throughout California; further, this practice is legal in many states. In addition, he stated that healthcare districts are the only public agency in California not allowed to employ physicians, something worthy of changing.

Many of the physicians currently working at this hospital are planning to retire soon, and recruiting and retaining new physicians is a problem due to lack of job security. Employment opportunities would address that concern. However, being able to hire only one or two physicians under the pilot does not address the real need.

There were no problems with the physician who was employed; there were no consumer protection issues. This physician filled a need in the community for care in this specialty.

Mendocino Coast District Hospital: The hospital administrator stated that this physician would not have come to this area if not hired as an employee. This physician has been instrumental in the development of a specialty clinic and treatment center, a tremendous asset to both the hospital and community.

This physician's presence in the community increased access to care in this rural community; the patients in need of this specialty care were able to receive local care, which was previously not available.

In support of the pilot, the administrator said that the ability to employ physicians allows for greater clinical integration between hospitals and physicians.

Pioneers Memorial Hospital: This hospital hired two physicians. With the addition of the first physician to the staff, the hospital was able to open a new primary care clinic, which then expanded to include an after-hours urgent care center. This facility has 9,000 patient visits annually, mainly Medi-Cal patients. This facility is also designated as a Rural Health Center.

Hiring the second physician allowed expanded services to the business community via the only hospital-based Worker's Compensation Clinic in the area, which was previously served only a few hours a week by three part-time physicians. This facility works with over 600 businesses; these services have greatly improved back-to-work time, which increased productivity in the community and have allowed patients to see local physicians instead of having to drive about two hours, as previously necessary. There seems to be greater patient satisfaction by having the continuity of care by one physician who is always available; further, by operating the clinic full-time, the hospital has been able to justify upgraded facilities.

This administrator indicated that improved recruitment packages offering employment might be a vehicle to attract new physicians to the area. However, the two physicians actually hired under SB 376 already were living and working in the area and this program was used as a method of retention, so neither would retire or move away.

Having these two additional physicians has improved long-term viability of the hospital, a facility at which the vast majority of current physicians are looking at probable retirement in the next five to 10 years.

Lastly, the accounting staff at the hospital has commented that the paperwork for an employed physician is significantly less than the billing paperwork required for a contracted physician.

Normally, this hospital recruits new physicians using "head hunting" firms. However, both of the physicians hired under the pilot were personally known to the hospital administrator.

Comments from non-Participating Hospitals

Administrators from six of the non-participating hospitals communicated with the Board in reply to the letters sent. They agreed that the pilot seemed worthwhile in addressing the shortage of health professionals. They offered a variety of comments:

- The hospital administration supported the pilot but the medical staff did not approve a motion to hire a physician. Senior physicians saw it as a threat and believed that new physicians should "pay their dues."
- Employment of physicians could benefit the hospital.
- Most physicians want the security that comes with employment, not just a contract.
- Most physicians who leave the hospital go out of state for employment opportunities.
- One hospital wanted to offer employment opportunities to physicians currently on contract instead of hiring a new physician; however, so as not to show favoritism, they decided not to hire anyone.
- The three-year *[sic]* contracting limit in the pilot was a barrier; no one would want to give up private practice with uncertainty over job security.
- One hospital is located in a county with a population higher than the pilot's threshold; otherwise, would have tried to hire someone.
- Past recruitment has been difficult; recruiting firms indicate the greatest barrier is the lack of employment.
- Other public agencies can hire physicians, which should be extended to district hospitals.

One hospital administrator replied that the hospital has no interest in directly employing physicians. In his opinion, traditional contracts provide the services of a physician at a lower cost to the hospital and, he believes, a greater level of satisfaction to the physician.

Letters to three hospitals were returned because the facility was closed or the district no longer operated the hospital.

Conclusions

During the past years, discussions with numerous stakeholders, even beyond those participating in this pilot, continuously highlight that the availability of healthcare professionals is greatly lacking in California. Addressing improved access to healthcare is one of the goals of the SB 376 pilot.

From the responses received to the Board's queries about the pilot, there seems to be a universal belief that many physicians hesitate settling in California, especially rural areas of the state, because of the disincentive created by the laws governing the corporate practice of medicine—most physicians in California work as contractors, not employees. Hospital administrators view the prohibition of the corporate practice of medicine as complicating their ability to ensure adequate staffing. This is further exacerbated by contractors not realizing the same work-related benefits as an employee.

Admittedly, any one additional healthcare provider who offers services is going to increase access to healthcare, regardless of how minimally. And it is obvious from the responses received, that the six physicians who were employed under the pilot provided additional access to healthcare to the residents of their service area; some of the physicians offered specialty services not otherwise available, an even greater benefit.

Yet the Board regrets that there was not a larger pool of participants from whom to gather data which would allow for a more in-depth analysis. The potential of collecting data from only six physicians and five hospital administrators created a challenge. The fact that responses were provided from only three of the five participating hospitals and five of the six participating physicians further inhibits the potential for a valuable analysis.

Therefore, the Medical Board believes there may be justification to extend the pilot so that a better evaluation of the direct employment of physicians can be made.

State of California

Department of Consumer Affairs

Memorandum

To: Renée Threadgill, Chief of Enforcement
Medical Board of California

Date: July 1, 2008

From: Susan Goetzinger
Expert Reviewer Program

Subject: Results of the Expert Survey Questionnaires

Questionnaires Sent this quarter (April 1-June 30, 2008)	44
Feedback Received from the questionnaires sent this quarter	33 (75 percent)
Total Feedback Received for this quarter's report	36

Questions 1-9, *positive response*: Yes
Question 10, *positive response*: No
Questions 11, *positive response*: Yes
Questions 12-14, *positive response*: Yes

1	Were you provided sufficient information/evidence to allow you to render a medical opinion?	100 percent YES
2	Were you encouraged to render an unbiased opinion?	100 percent YES
3	Was the case directly related to your field of expertise?	100 percent YES
4	Were you given sufficient time to review the case? If not, how much time would have been appropriate for this review?	94 percent YES 6 percent NO
	No response-suggested 60 days	
5	Did the MBC staff meet your expectations to provide you with what you needed to complete your review? If no, what should have been provided to facilitate your review?	97 percent YES 3 percent did not respond
6	Did the training material provided to you (the Expert Reviewer Guidelines and videotape/DVD) give you adequate information to perform your case review?	97 percent YES 3 percent responded N/A
7	Were you given clear, concise, and easy to follow instructions throughout the process?	97 percent YES 3 percent responded N/A
8	Was the investigator and/or MBC staff readily available to answer questions or concerns about the case?	100 percent YES
9	Is the required written report adequate to cover all aspects of your opinion?	97 percent YES 3 percent responded N/A

10	Do you feel the MBC has requested your services more frequently than you would prefer?	97 percent NO 3 percent responded N/A
11	Would you be willing to accept more MBC cases for review?	100 percent YES
12	If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction?	8 percent YES 92 percent N/A
13	Did the Deputy Attorney General or his/her representative meet your expectations to provide you with what you needed prior to testifying? If no, what would have made testifying for the Board easier?	94 percent N/A 6 percent YES
14	Do you feel the reimbursement amount for case review is appropriate for the work you are required to perform?	66 percent YES 25 percent NO 6 percent N/A 3 percent did not respond
Level of satisfaction with overall experience performing case reviews for MBC		83 percent HIGH 14 percent AVERAGE 3 percent did not respond

SUGGESTIONS FOR IMPROVEMENT TO THE PROGRAM

The ability to dictate my reports would have been nice. Hand typing the reports is time consuming and adds expense to the review.
There should be a middle rating - simple, *moderate...* There was some discrepancy between the material I received re assigning the assessment from the Board & in the material I received re the actual case.
Realize that many times more records are needed and this may make the "30-day" due date harder.
Increase reimbursement. If possible, decrease time needed to get complete medical records-ask reviewers what parts of records are really needed to render quick reporting turnaround. Obtaining the proper records is the rate-limiting step in reporting.

COMMENTS REGARDING REIMBURSEMENTS

Specialists want to help with this important public service, but the current rate of $150 may not be sufficient to attract additional specialists for these reviews. For background & to help with your planning, most of my colleagues who provide case reviews, consultation or testifying service generally charge hourly rates of $350-450.

Reimbursement could be higher - most medical expert case analysis average $400-600/hr and then more if required to appear, so this is really a public service which I feel is important to protect the public.
$200/hr more reasonable as subspecialist expert
$150/hr is appropriate, but review + report required longer time than anticipated. *(spent over 10 hrs, but only charged 10)*
The reimbursement rate is low. For private medical legal cases I do, I charge $300 for chart review & research $500 for depos & testimony.

GENERAL COMMENTS

Superb support.
I am happy to do medical reviews.
I thoroughly enjoy reviewing cases for the MBC. I welcome reviewing future cases. It is a delight and pleasure working with everyone from MBC.
Both Dr. Snider & Ms. Holloway were readily available and responsive to questions and requests.
I would prefer that the MBC requested my services more frequently
No suggestions for improvement, first review went very well. Given the high volume of records to review in this case, and the subsequent lengthy report, the expectation that work be accomplished in 10 hours or less was unrealistic.
I feel under utilized which hopefully means few radiology cases are occurring. Regarding reimbursement rate, I have very little free time and when I do such reviews for medical cases, I charge more per hour for my time. That being said, I believe so strongly in peer review that I would gladly review MBC cases for No Fee. I believe that if the physicians do not do this, then someone less informed will, by default. I am very impressed with the effort spent and quality of work product in the investigation and data collection of MBC cases. Thank you for the opportunity to participate.
would be of great help to reviewers if the records are in chronological order as much as possible

I really enjoy document review. I think $150/hr is low but at present fair fee - appropriate because I see my reviews in part as an aspect of public service. It is necessary. I have seen more patients die or put at real risk in my 2 years in LA than in 25 years in Wash. DC. I think the review process could be improved - i.e. made more efficient - & I'd be happy to take part in discussions as to how this might be done. I think the Investigators are very professional, dedicated & do an excellent job.
I'm always willing to review cases if appropriate to my specialty, so keep them coming! Thanks for the opportunity to participate in the program. It is interesting, I always learn a lot and hope I'm helping to contribute to patients safety. The investigators have been really helpful!
I am always impressed with the investigative reports from your staff. Marybeth Rodriguez is delightful to work with.
Excellent support with Medical Board!

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

Calendar Year (2008)

SPECIALTY	Number of cases reviewed/sent to Experts Jan-June 2008	Number of Experts used and how often utilized Jan-June 2008	Active List Experts Y-T-D (TOTAL= 1,173 ↑)
ADDICTION			11
AEROSPACE MEDICINE			1
ALLERGY & IMMUNOLOGY			10
ANESTHESIOLOGY	11	9 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	90
BIOETHICS			1
COLON & RECTAL SURGERY			5
COMPLEMENTARY/ALTERNATIVE MEDICINE			13
CORRECTIONAL MEDICINE	5	2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	11 ↑
DERMATOLOGY	5	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	12
EMERGENCY	14	13 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	63 ↓
ETHICS	1	1 LIST EXPERT	2 ↑
FAMILY	26	21 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	97
HOSPICE & PALLIATIVE CARE			7
INTERNAL General Internal Med & sub-specialties not listed below	29	24 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	238 ↑
INTERNAL - CARDIOLOGY Interventional Cardiology	7	7 LIST EXPERTS	35 ↑ [23↑]
INTERNAL-ENDOCRINOLOGY & METABOLISM			9
INTERNAL - GASTROENTEROLOGY			18
INTERNAL -INFECTIOUS DISEASES			10
INTERNAL - NEPHROLOGY			8
INTERNAL - ONCOLOGY			13 ↑
MEDICAL GENETICS			1
MIDWIFE			12
NEUROLOGICAL SURGERY	4	2 OUTSIDE EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	15
NEUROLOGY	1	1 LIST EXPERT	20 ↓

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
(CALENDAR YEAR TO DATE : JAN-JUNE 2008)
Page 2

NEUROLOGY (CHILD)			5 ↑
OBSTETRICS & GYNECOLOGY	20	11 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	89 ↑
REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY			6 ↑
OCCUPATIONAL MEDICINE	1	1 LIST EXPERT	8
OPHTHALMOLOGY	7	7 LIST EXPERTS	49
ORAL & MAXILLOFACIAL SURGERY			1
ORTHOPAEDIC SURGERY	14	10 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES & 1 SUPPLEMENTAL REVIEW	49
OTOLARYNGOLOGY	2	2 LIST EXPERTS	33
PAIN MEDICINE ((18ABMS↑; 12 ABPM = 31)	8	2 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	26 ↓
PATHOLOGY (Anatomic/Clinical-12; Anatomic-1)	1	1 LIST EXPERT	13
PEDIATRICS	1	1 LIST EXPERT	66 ↑
PEDIATRIC CARDIOLOGY	1	1 LIST EXPERT	5
PEDIATRIC CARDIOTHORACIC SURGERY	1	1 LIST EXPERT	2 ↑
PEDIATRIC HEMATOLOGY/ONCOLOGY			5
PEDIATRIC INFECTIOUS DISEASES (BOARD CERTIFIED)			3
PEDIATRIC SURGERY			2 ↓
PHYSICAL MEDICINE & REHABILITATION			9 ↓
PLASTIC SURGERY	13	11 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	50 ↑
PSYCHIATRY	34	25 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES (1 CASE REVIEW, 2 MENTAL EVALS) 1 LIST EXPERT REVIEWED 4 CASES (1 CASE REVIEW, 2 MENTAL EVALS, 1 PREP & TESTIMONY)	111 ↓
PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE			6
RADIOLOGY (3↓) DIAGNOSTIC RADIOLOGY-32 ↑ NUCLEAR MEDICINE-6	9	4 LIST EXPERTS REVIEWED 1 CASES 1 LIST EXPERT REVIEWED 5 CASES (name flagged from database)	35 ↓
VASCULAR/INTERVENTIONAL RADIOLOGY (Board Certified)			2
RADIATION ONCOLOGY -4 / THERAPEUTIC RADIOLOGY -2			6

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
(CALENDAR YEAR TO DATE : JAN-JUNE 2008)

SLEEP MEDICINE			8
SPINE SURGERY (ABSS-MBC APPROVED)			1
SURGERY	9	7 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	60 ↑
THORACIC SURGERY	6	6 LIST EXPERTS	20 ↑
VASCULAR SURGERY	1	1 LIST EXPERT	6
UROLOGY	5	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	17
WORKERS' COMP/QME/IME			8 ↑

/susan (6/30/08)

MEDICAL BOARD AND HEALTH QUALITY ENFORCEMENT REPORT

DATE REPORT ISSUED:	July 14, 2008
DEPARTMENT:	Enforcement Program
SUBJECT:	Recommendations to Decrease Timeframes for Medical Board Enforcement Process
STAFF CONTACT:	Renee Threadgill

REQUESTED ACTION:
Members adopt staff's recommendations.

STAFF RECOMMENDATION:
Recommendations impacting Investigation Timeframes:

1) Increase compensation for Board investigators and provide incentives for retention (field training officer pay, geographic differential pay, etc.).
2) Increase the number of investigator positions.
3) Work with DCA to amend the specifications for the investigator classification series to expand the subject areas of the degrees accepted for admission to the examination.
4) Request DCA personnel examination unit to provide an ongoing schedule for investigator examinations in order to maintain a current viable list of potential new hires.
5) Subpoenas that are required during the investigative process shall, upon request, be completed by the Attorney General's (AG) Office.
6) Amend Business and Professions Code section 2225.5(a) to allow the Board to access medical records with patient notification, rather than patient consent or a subpoena.
7) Continue to support amending legislation to require certification of medical records upon request by the Board.

Recommendations impacting Prosecution Timeframes:

1) The AG's Office will complete draft Accusations within 60 days of receipt of the completed investigation.
2) The AG's Office will send copies of the Notice of Defense and the Request for Hearing to the Board at the time they are filed with the Office of Administrative Hearings.
3) The Board and the AG's Office will review and reconcile monthly status reports on cases pending at the AG's office that are pre and post accusation.
4) Executive Board staff will continue to meet with Executive staff at the AG's Office on a regular basis to discuss the status of open cases.
5) All hearing continuances requested by the AG's Office must be approved by Board staff, based upon a request setting forth the reasons for the continuance.

Recommendations impacting Hearing Timeframes:

1) The Board request OAH hear Medical Quality Hearing Panel cases within 120 days of receipt of the Request for Hearing.
2) The Board request OAH limit granting continuances only for *good cause*.
3) The Board request OAH mandate early settlement conferences.
4) The Board request OAH to assign Board cases only to Administrative Law Judges assigned to special panel designated to hear Medical Board cases.

EXECUTIVE SUMMARY:
In an effort to reduce the timeframe for investigating, prosecuting, hearing, issuing a decision, and adopting a decision, the Medical Board of California (Board) and the Attorney General's (AG) Office have been reviewing current processes to determine how to decrease these timeframes. The vertical enforcement model was developed as a result of deficiencies pointed out by the Enforcement Monitor in 2005. In their continuing commitment to improve the timeframes for the enforcement process the Board and the AG's Office enforcement

and prosecution teams have been successful in developing documents including; the *Vertical Prosecution Manual* in 2006; and more recently the *Vertical Enforcement Guidelines* in 2008. The recommendations listed herein have been topics of discussion between the Board and the AG's Office. The recommendations provided in this document, once adopted and implemented, should result in a reduction of time. Based on the statistics for actions taken in Fiscal Year 2007/2008 it took an average of 1064 calendar days to achieve final disposition with respect to matters that were prosecuted (see attached). The Board believes that if the recommendations set forth below are implemented, an average reduction of 399 calendar days will be realized.

The time it takes to investigate, prosecute and have a decision issued by the Board is impacted by a number of factors under the control of the Board, the AG's Office, and the Office of Administrative Hearings (OAH). While none of the aforementioned entities has entire control over all of the factors impacting the timeframe, each has control over certain aspects. Consequently, modification of the manner in which each entity fulfills its responsibility with regard to the investigation, prosecution and adjudication of the matters at issue will, we believe, result in a times savings with respect to achieving final disposition of Board disciplinary matters.

The timeframe of the investigative aspect of the process can be greatly reduced from the current timeframe of 400 days to 275 days (the statutory goal for complex cases). To assist in achieving this goal, there should be a clearer understanding between the Board and the AG's Office as to what is expected and what is not acceptable with regard to the services provided during investigations. In reviewing the investigative process, Mr. Ramirez and Ms. Threadgill worked to develop the recommendations listed above.

Mr. Ramirez and Ms. Threadgill have been in discussion regarding strategies to decrease prosecution timeframes, and have developed the above recommendations. The Board Enforcement Staff and the AG's office will work together to monitor all cases at the AG's office to ensure timely progress on all cases. For the hearing timeframes, the Board must clarify what is expected of the OAH. Board staff will meet with Ron Diedrich, Director and Chief Administrative Law Judge, to discuss recommendations pertaining to OAH.

We believe that if the foregoing recommendations are implemented, greater efficiency will be realized with respect to the enforcement process.

The goal of the aforementioned plan is to:

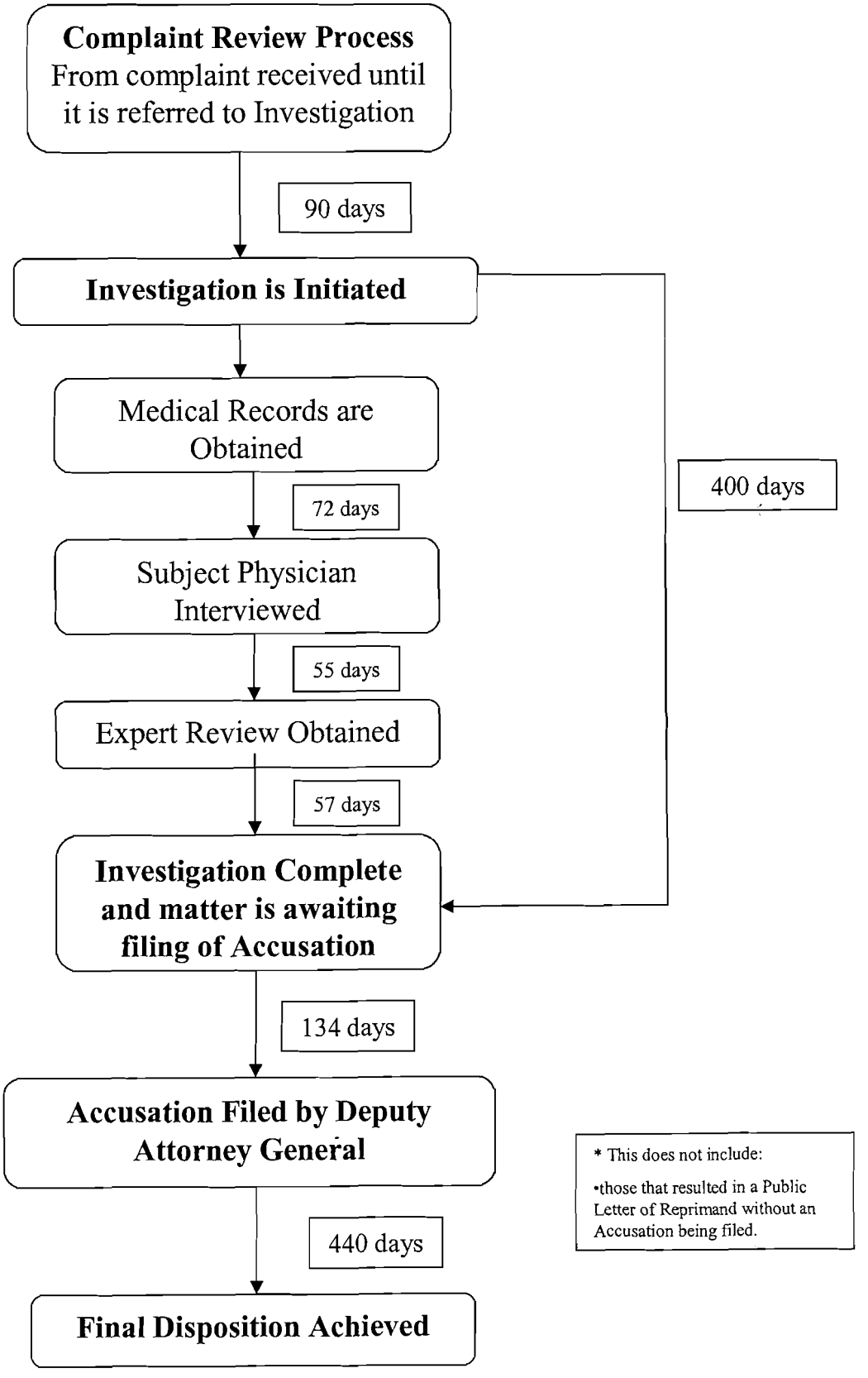
➢ Complete complaint unit processing:	90 days
➢ Complete the investigation:	275 days
➢ Complete the accusations:	60 days
➢ Complete the administrative hearing	180 days
➢ Adopt the decision within two months of receipt of proposed decision or stipulation	60 days
Total time for discipline from receipt of complaint through adjudication	**655 days**
Current Timeframe	**1064 days**

FISCAL CONSIDERATIONS:
To be determined.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
At the previous Board Meeting, Members asked Mr. Ramirez and Ms. Threadgill to prepare a report regarding recommendations for timeframe reductions in the enforcement process.

Medical Board of California
Enforcement Process – Includes Pre Vertical Enforcement and Post Vertical Enforcement Cases
Cases with Final Dispositions from 7/1/07 to 6/30/08 – 250 actions*

(days in boxes are the average calendar days)



* This does not include:

•those that resulted in a Public Letter of Reprimand without an Accusation being filed.

Meeting Month/Year	Physician's & Surgeon's Applications	Number of Calendar Days to Initial Review (Low)	Number of Calendar Days to Initial Review (High)	Number of Calendar Days to Initial Review (Average)
July-08	US/CAN	54	114	84
July-08	IMG	1	115	58
April-08	US/CAN	77	96	88
April-08	IMG	36	82	66
February-08	US/CAN	54	96	76
February-08	IMG	35	110	71
November-07	US/CAN	18	50	30
November-07	IMG	37	87	65
July-07	US/CAN	25	43	38
July-07	IMG	21	61	46
Historical Information				
April-07	US/CAN	34	55	43
April-07	IMG	15	56	33

FY 07/08	Number of Physician's & Surgeon's Applications Received	Number of Physician's & Surgeon's Licenses Issued
1st Quarter	1,465	1,271
2nd Quarter	1,540	904
3rd Quarter	1727	1014
4th Quarter	1522	1598
TOTAL	6,254	4,787

FY 07/08	Number of Physician's & Surgeon's Applications Received	Number of Physician's & Surgeon's Licenses Issued
TOTAL	6,254	4,787

Special Program FY 07/08	2111 Applications Processed	2112 Applications Processed	2113 Applications Processed	2168 Applications Processed
1st Quarter	24	1	17	1
2nd Quarter	4	0	3	4
3rd Quarter	6	0	4	4
4th Quarter	13	0	19	2
TOTAL	47	1	43	11

Special Program FY 07/08	2072 Applications (Correctional Facility) Processed	Hospital 1327 Renewals/Site Visits	Medical School 2111/2113 Site Visits
1st Quarter	0	1	0
2nd Quarter	0	0	1
3rd Quarter	0	0	0
4th Quarter	0	1	1
TOTAL	0	2	1.5

Prepared: July 8, 2008

Consumer Information Unit Activity FY 07/08	Number of Calls Answered	Number of Callers Connected to an Operator Immediately	Percent of Callers Who Experienced a Two Minute or Less Wait Time
1st Quarter	17,269	9,686	56%
2nd Quarter	17,662	9,144	52%
3rd Quarter	16,109	7,193	45%
4th Quarter	20,338	*n/a	*n/a
TOTAL	71,378	26,023	NA

LICENSED MIDWIFE ACTIVITY 2007/2008			
Licenses Issued	Applications Received	Applications Pending	Applications Denied
7	12	5	0

Licenses Current/Renewed (as of May 31, 2008)	Licenses Delinquent (as of May 31, 2008)	Licenses Canceled (as of May 31, 2008)
175	22	16

*information n/a, as Verizon system hasn't been implemented

Prepared: July 8, 2008

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 11, 2008
DEPARTMENT:	Licensing Program
SUBJECT:	Special Faculty Permit Review Committee Appointment
STAFF CONTACT:	Deborah Pellegrini

REQUESTED ACTION:

Approval of the appointment of F. Allan Hubbell, M.D. to serve on the Special Faculty Permit Review Committee.

STAFF RECOMMENDATION:

The University of California, Irvine (UCI) has nominated Dr. F. Allan Hubbell as their new representative for the Special Faculty Permit Review Committee. This nomination comes as a result of the retirement of Dr. Jeremiah G. Tiles. Staff recommends approval of Dr. Hubbell's appointment to represent UCI on the Special Faculty Permit Review Committee.

EXECUTIVE SUMMARY:

Section 2168.1 (c) of the Business and Professions Code states the Board shall establish a review committee comprised of two members of the Board, one of who shall be a physician and surgeon and one of whom shall be a public member, and one representative from each of the medical schools in California. The committee shall review and make recommendations to the Board regarding the applicants applying pursuant to this section, including those applicants that a medical school proposes to appoint as a division chief or head of a department or as nontenure track faculty.

Due to the retirement of Dr. Jeremiah G. Tiles, from the University of California, Irvine on July 1, 2008, a new representative to serve on the Special Faculty Permit Review Committee has been nominated by the medical school dean. Please find attached for your review the nomination letter and Curriculum Vitae for Dr. Hubbell.

FISCAL CONSIDERATIONS:

None.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

In both February and April 2007, the Board accepted and approved nominations for representatives to this Committee.

UNIVERSITY OF CALIFORNIA, IRVINE

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SCHOOL OF MEDICINE
OFFICE OF THE DEAN

252 IRVINE HALL
IRVINE, CALIFORNIA 92697-3950

June 26, 2008

California Medical Board
Attention: Cindi Oseto
2005 Evergreen Street
Suite 1200
Sacramento, CA 95815

Dear Ms. Oseto,

I, herby, nominate Dr. F. Allan Hubbell as the new representative to the Special Programs Board from the University of California, Irvine. The current representative, Dr. Jeremiah G. Tilles, will be retiring effective July 1, 2008.

Very sincerely yours,

David N. Bailey, M.D.
Vice Chancellor, Health Affairs

C: F. Allan Hubbell, M.D., M.S.P.H.
Senior Associate Dean

CURRICULUM VITAE

F. Allan Hubbell, M.D., M.S.P.H.
Professor of Medicine and Public Health
Senior Associate Dean for Academic Affairs
School of Medicine
University of California, Irvine
E-mail: fahubbel@uci.edu

264 Irvine Hall
1001 Health Sciences Road
Irvine, CA 92697-3905
TEL: 949-824-3975
FAX: 949-824-2676

EDUCATION:

Graduate School:	M.S.P.H. 1981-83	University of California, Los Angeles, California
Residency:	Internal Medicine 1975-78	University of California, Irvine-Long Beach Medical Program, Long Beach/Irvine, California
Medical School:	M.D. 1971-74	Baylor College of Medicine, Houston, Texas
College:	B.A. 1967-71	Baylor University, Waco, Texas

MEDICAL LICENSURE: Texas (E-3710), 1975
California (C-37079), 1978

BOARD CERTIFICATION: Diplomate, American Board of Internal Medicine, 1978

ACADEMIC APPOINTMENTS:

Current	Senior Associate Dean for Academic Affairs, School of Medicine (2008-) Professor of Medicine (1997-) and Public Health (2007-) Senior Research Fellow, Center for Health Policy Research (2001-) University of California, Irvine, California
2001-2008	Chair, Department of Medicine University of California, Irvine, California
1992-2001	Chief, Division of General Internal Medicine and Primary Care Director, Center for Health Policy Research University of California, Irvine, California
1993-98	Director, Primary Care Internal Medicine Residency Program University of California, Irvine, California
1989-97	Associate Professor of Medicine University of California, Irvine, California

ACADEMIC APPOINTMENTS (continued):

1981-89	Assistant Professor of Medicine University of California, Irvine, California
1979-81	Assistant Chief of Medicine for Education V.A. Medical Center, Long Beach, California
	Assistant Clinical Professor of Medicine University of California, Irvine, California
1978-79	Staff Member, General Internal Medicine Section V.A. Medical Center, Long Beach, California

PROFESSIONAL ACTIVITY:

Awards and Honors:

Guide to America's Top Physicians, 2002-present
Roger K. Larson Visiting Professorship, University of California, San Francisco – Fresno, 2006
Governor's *Guahan* (Guam) Award for outstanding contributions to the island of Guam and her People in cancer prevention and control, 2005
Honorary *Matai* (Chief) for contributions to improving cancer control for Tongans, Samoans and Chamorros, Pacific Islander Cancer Control Network, 2005
National Cancer Institute, Community Health Research Leadership Award, Center to Reduce Cancer Health Disparities, 2004
Who's Who in America and Who's Who in Medicine and Health Care, 1996-present
Certificate of Recognition for contributions to the American Samoan community presented by the Mayor of Carson, California, 1997
Certificate of Recognition for Outstanding Teaching, Primary Care Internal Medicine Residency, University of California, Irvine, 1991
Teacher of the Year Award, Primary Care Clerkship, University of California, Irvine, 1989
Faculty of the Year Award for Excellence in Clinical Teaching, Department of Medicine, University of California, Irvine, 1987
Certificate of Appreciation for work in cost containment, V.A. Medical Center, Long Beach, California, 1985
Outstanding Faculty Member, College of Medicine, University of California, Irvine, 1983
Moody C. Bettis Award for Excellence in Community Medicine, Baylor College of Medicine, 1974
Hamilton Fish Scholarship, Baylor College of Medicine, 1971-74

Contracts, Grants and Research Awards:

- Current Research

Name: Women's Health Initiative: Clinical Center for the Clinical Trial and Observational Study (N01 WH4-2107)
Funding Agency: National Heart, Lung, and Blood Institute
Role: Principal Investigator (5% effort)
Amount: Total direct costs - $10,845,779; Current year - $231,493
Dates: October 1994 - September 2010

- **Current Research** (continued):

Name: Women's Health Initiative Memory Study (CT 22775)
Funding Agency: Wake Forest University School of Medicine
Role: Principal Investigator (subcontract, 2% effort)
Amount: Total direct costs - $179,112; Current year - $29,852
Dates: June 1996 - May 2010

Name: Health Disparities and Outcomes Research Committee
Funding Agency: University of Michigan/Southwest Oncology Group
Role: Principal Investigator (subcontract, 7.5% effort)
Amount: Total direct costs - $10,761; Current year - $10,761
Dates: March 2008 – December 2008

Name: Single Visit Cervical Cancer Prevention Program (R01 CA76502)
Funding Agency: National Cancer Institute
Role: Co-Investigator (5% effort)
Amount: Total direct costs - $2,132,326; Current year - $409,263
Dates: July 1998 - June 2008

- **Completed Research**

Name: Pacific Islander Cancer Control Network (U01 CA86073)
Funding Agency: National Cancer Institute
Role: Principal Investigator (20% effort)
Amount: Total direct costs - $3,021,857
Dates: April 2000 – March 2007

Name: University of California Irvine Cancer Center Support Grant (P30 CA62203)
Funding Agency: National Cancer Institute
Role: Co-Leader, Population Sciences Research Program (5% effort)
Amount: Total direct costs - $8,073,125; Current year - $868,005
Dates: September 1994 - August 2006

Name: A Randomized Controlled Trial of Fat Reduction, Calcium/Vitamin D Supplementation, Hormone Replacement Therapy, and Risk of Proliferative Forms of Benign Breast Disease: Women's Health Initiative Ancillary Study
Funding Agency: Albert Einstein College of Medicine
Role: Principal Investigator (subcontract, 2% effort)
Amount: Total direct costs - $24,000
Dates: July 2001 – June 2006

Name: A Network Based Intervention for Chamorros in Southern California (7BB-1901)
Funding Agency: California Breast Cancer Research Program
Role: Co-Investigator (5% effort)
Amount: Total direct costs - $206,214, Current year - $76,260
Dates: July 2001-June 2004

- **Completed Research** (continued):

Name: Women's Health Initiative-Sight Examination (Subcontract #970423)
Funding Agency: University of Michigan
Role: Principal Investigator (subcontract, 2% effort)
Amount: Total direct costs - $129,362, Current year - $61,020
Dates: February 2000 – December 2004

Name: Latina Cervical Cancer Survivorship: A Developmental Study (R21 CA97191)
Funding Agency: National Cancer Institute
Role: Co-Investigator (2% effort)
Amount: Total direct costs $200,000, Current year - $100,000
Dates: July 1, 2002 – June 30, 2004

Name: UCI/UCSD Cancer Genetics Network (U24 CA78134)
Funding Agency: National Cancer Institute
Role: Co-Investigator (5% effort)
Amount: Total direct costs - $2,221,219, Current year - $613,756
Dates: March 1998 - February 2004

Name: University of California Irvine Cancer Center Support Grant Supplement: Innovative Cancer Control Initiatives in Cancer Centers (P30 CA62203)
Funding Agency: National Cancer Institute
Role: Co-Principal Investigator (5% effort)
Amount: Total direct costs - $300,000
Dates: March 1999 - February 2002

Name: Addressing Survey Implementation Issues among Urban American Indians
Funding Agency: The California Endowment
Role: Principal Investigator (15% effort)
Amount: Total direct costs - $201,976
Dates: February 2000 – January 2002.

Name: Access to Public Health Insurance among Urban American Indians in California
Funding Agency: Tomas Rivera Policy Institute
Role: Principal Investigator (15% effort)
Amount: Total direct costs - $204,000
Dates: April 2000 – March 2002.

Name: Myocardial Ischemia and Migraine Study: Ancillary Study Women's Health Initiative
Funding Agency: Maryland Medical Research Institute
Role: Principal Investigator (2% effort)
Amount: Total direct costs - $59,845
Dates: July 1998 – June 2001

Name: Samoans and Breast Cancer: Evaluating a Theory Based Program (4BB-1401)
Funding Agency: University of California Breast Cancer Research Program
Role: Co-Investigator (5% effort)
Amount: Total direct costs - $153,955
Dates: July 1998 - June 2001

- **Completed Research** (continued):

Name: Cancer Control Needs among Native American Samoans (U01 CA64434)
Funding Agency: National Cancer Institute/National Office of Samoan Affairs
Role: Principal Investigator (20% effort)
Amount: Total direct costs - $481,727
Dates: October 1994 - September 2000

Name: Medical Education for the 21st Century
Funding Agency: PacifiCare Health Systems Corporation
Role: Co-Investigator (10% effort)
Amount: Total direct costs - $769,628
Dates: July 1997 - June 2000

Name: Impact of Latina's Beliefs about Cervical Cancer on Pap Smear Use
Funding Agency: Chao Family Comprehensive Cancer Center
Role: Principal Investigator (5% effort)
Amount: Total direct costs - $9,972
Dates: November 1997 - October 1998

Name: Training Program in Primary Care Internal Medicine (D28 PE19154)
Funding Agency: Department of Health and Human Services
Role: Principal Investigator (25% effort, 1993-97): Associate Director (30% effort, 1990-93); Co-Investigator (40% effort, 1984-90)
Amount: Total direct costs - $2,981,870
Dates: July 1979 - June 1997

Name: Cancer Control among Hispanic Women (R01 CA52931)
Funding Agency: National Cancer Institute
Role: Principal Investigator (30% effort)
Amount: Total direct costs - $767,831
Dates: September 1991 - August 1995

Name: Cancer Control Career Development Award for Primary Care Physicians
Funding Agency: American Cancer Society
Role: Faculty Mentor (10% effort)
Amount: Total direct costs - $55,000
Dates: July 1993 - June 1995

Name: Cancer in the Latino Community
Funding Agency: Latino Related Organized Research, University of California, Irvine
Role: Co-Investigator (10% effort)
Amount: Total direct costs - $7,000
Dates: July 1991 - June 1992

Name: Baseline Laboratory Testing in the Elderly
Funding Agency: Academic Geriatric Resource Center, University of California, Irvine
Role: Principal Investigator (5% effort)
Amount: Total direct costs - $2,500
Dates: July 1989 - June 1990

- **Completed Research** (continued):

Name: Community-Oriented Surveillance of Health Care in Orange County, California
Funding Agency: Center for Orange County Research
Role: Principal Investigator (5% effort)
Amount: Total direct costs - $5,000
Dates: July 1988 - June 1989

Name: Needs Assessment of Health Services for Residents of North Orange County
Funding Agency: St. Joseph Health System Foundation
Role: Co-Investigator (10% effort)
Amount: Total direct costs - $50,018
Dates: July 1987 - June 1988

Name: Residency Training Program in General Internal Medicine (5 D28 PE19175)
Funding Agency: Department of Health and Human Services
Role: Co-Principal Investigator (30% effort)
Amount: Total direct costs - $225,000
Dates: July 1984 - June 1987

Name: Residency Training Program in General Internal Medicine (D28 PE19162)
Funding Agency: Department of Health and Human Services
Role: Co-Principal Investigator (30% effort)
Amount: Total direct costs - $275,000
Dates: July 1980 - June 1983

Offices in Professional Societies:

Co-Chair, Health Disparities and Outcomes Research Committee, Southwest Oncology Group, 2008-present
Scientific Program Director, Southwest Region, Society of General Internal Medicine, 1987-88
Co-Chair, Southwest Region, Society of General Internal Medicine, 1983-86

Membership on Journal Editorial Boards:

American Journal of Medicine, Editorial Board, 2005-present
Cancer Detection and Prevention, Guest Editor, 2008
The Clinical Journal of Women's Health, Editorial Board, 2000-02
Health Education Quarterly, Guest Editorial Board, 1994-96

Service to Professional Societies:

Southwest Oncology Group
- Co-Chair, Health Disparities and Outcomes Research Committee, 2008-present

Association of Professors of Medicine
- Nominating and Membership Committee, 2005-present
- Education Committee, 2004-present

Society of General Internal Medicine:
- Co-Chair, Abstract Selection Committee, National Meeting, Los Angeles, California, 2006
- Abstract Selection Committee, National Meeting, New Orleans, Louisiana, 2005
- Abstract Selection Committee, National Meeting, Atlanta, Georgia, 2002
- Co-Chair, HRSA Abstract Selection Committee, National Meeting, San Diego, California, 2001
- Co-Chair, Abstract Selection Committee, National Meeting, San Diego, California, 1995
- Abstract Selection Committee, Regional Meeting, Santa Monica, California, 1994
- Workshop Selection Committee, National Meeting, Washington, DC, 1990
- Technology Assessment Committee, 1986-88
- Bylaws Committee, 1985-87
- Co-Chair, California Region, 1985-87

Western Association of Physicians
- Chair, Health Care Research Abstract Session, Annual Meeting, Carmel, CA 2007
- Health Care Research Abstract Review Committee, Annual Meeting, Carmel, CA 2006

National Board of Medical Examiners, USMLE Step 3 Acute Care Test Material Development Committee, 2002-04

Service as Journal Reviewer:

Journal of the National Cancer Institute, 2001-present
Preventive Medicine, 2000-present
Archives of Internal Medicine, 1994-present
Health Education Quarterly, 1994-present
American Journal of Medicine, 1990-present
Annals of Internal Medicine, 1990-present
American Journal of Public Health, 1989-present
Medical Care, 1988-present
Journal of the American Medical Association, 1987-present
Journal of General Internal Medicine, 1985-present
New England Journal of Medicine, 1985-present

Service as Referee of Proposals/Programs:

National Cancer Institute, Special Emphasis Panel for Competitive Supplements for Pilot Projects for Community Networks Program to Reduce Cancer Health Disparities (U01), 2007
National Cancer Institute, Special Emphasis Panel for Planning Grants for Minority Institution/Cancer Center Collaborations (P20); Cooperative Planning Grants for Comprehensive Minority Institution/Cancer Center Partnerships (U56); and Comprehensive Minority Institution/Cancer Center Partnerships (U54), 2005-present (Chair, 2006-07)
National Cancer Institute, External Program Steering Committee, University of Guam/Cancer Research Center of Hawaii Partnership (U56 CA03008), Chair, 2003-present
National Cancer Institute, External Program Steering Committee, California State University, San Diego/University of California, San Diego Cancer Center Partnership (U56 CA92081), 2002-present
Centers for Disease Control and Prevention, Special Emphasis Panel for Mentored Research Scientist Development Award (K01), 2004
National Cancer Institute, Special Emphasis Panel for Community Clinical Oncology Programs Award (U10) and Minority Based Community Clinical Oncology Programs Award (U10), 2000
California Program on Access to Care Advisory Board, 1999-2002
UCI Center for Complementary and Alternative Medicine Advisory Board, 1999-2001
Innovative Cancer Control Initiatives in Cancer Centers (P30 CA62203 supplement), 1999-2002
Universitywide Wellness Lectures Series Steering Committee 1996-98
UCI College of Medicine Committee on Research, 1994-97
UCI Cancer Center Translational Grants Selection Committee, 1994-97
National Cancer Institute, Special Emphasis Panel for Public Health Approaches to Breast and Cervix Screening, 1991
UCI College of Medicine Selection Committee, Medical Education/Research Funds, 1989

Membership in Professional Organizations:

Southwest Oncology Group, 2008-present
Western Association of Physicians, 2003-present
American College of Physicians, Member 1979-82; Fellow 1982-present
Society of General Internal Medicine, 1979-present
American Public Health Association, 1981-present
Physicians for Social Responsibility, 1985-present
Association of Professors of Medicine, 2001-08
American Federation for Clinical Research, 1981-91

UNIVERSITY AND PUBLIC SERVICE:

Universitywide:

California Health Benefits Review Program, 2002-03
Committee on Affirmative Action and Diversity, 1999-2002
California Program on Access to Care Advisory Board, 1999-2001
Ad Hoc Committee on the Medical Corporate Compliance Plan, 1999-2000
Planning Committee on Primary Care Education, 1994-99
Wellness Lectures Program Steering Committee, 1996-98

Campus:

Academic Senate Cabinet, 2001-02
Council on Faculty Welfare, Rights, Responsibilities, and Diversity, 1999-2002 (Chair, 2001-02)
Institutional Review Board (IRB-C) for Social and Behavioral Research, 1998-2002
Representative Assembly, Irvine Division of the Academic Senate, 1986-88, 1989-91,1994-96, 1999-2001
Task Force on the Feasibility of Establishing a School of Public Health, 2000-01
Ad Hoc Cornmittee on Survey Research, 1993

School of Medicine:

Representative Assembly, 1992-2000, 2002-06, 2007-present
Council of Clinical Chairs, 2001-08
Dean's Advisory Board, 2001-07
Search Committee for Chair of the Department of Family Medicine (Chair), 2001-02
Academic Resources Advisory Council, 1997-2002
Clinical X Committee, 1996-2002
Health Systems Capital Planning Committee, 1996-2000
General Clinical Research Center Advisory Board, 1999-2000
Academic Planning Council, 1997-98
Search Committee for Chair of the Department of Medicine, 1997-98
Search Committee for Biostatistics faculty member, 1996-98
Committee on Research, 1994-97
Dean's Committee on the Status of Women in the College of Medicine, 1990-97
Search Committee for Genetic Epidemiology faculty member, 1996
Search Committee for Environmental Epidemiology faculty member, 1996
Search Committee for Chair of the Department of Family Medicine, 1995-96
Allied Health Committee, 1993-96
Search Committee for Director of the Emergency Medicine Department (Chair), 1994-95
Blue Ribbon Committee on Medical Education, 1993-94
Blue Ribbon Subcommittee on Faculty Development, 1993-94
Committee on Postgraduate Clinical Programs, 1988-94
Primary Care Working Group (Subcommittee of Universitywide Working Group), 1992-93
Ad Hoc Committee on a Representative Assembly for the College of Medicine, 1991-92
Task Force on Perinatology, 1990-91
Admissions Committee, 1989-91
Selection Committee for Medical Education/Research Funds, 1989
Search Committee, Associate Dean for Student and Curricular Affairs, 1987-88
Honors Day Committee, 1985-87 (Chair, 1986-87)
Promotions and Honors Committee, 1984-87

Department of Medicine:

Chair, 2001-08
Faculty Development Committee, 1999-2002
FTE Allocation Committee, 1999-2002
Resident Review Committee, 1990-98
Associate Director, Primary Care Internal Medicine Residency Program, 1990-93
Curriculum Committee, Primary Care Internal Medicine Residency, 1985-98
Director, General Internal Medicine Fellowship Program, 1985-96
Mid-Career Evaluation Committee, 1992-93
Curriculum Committee, 1985-89
Director, Intermediate Medicine Clerkship, 1985-89
Director, Senior Medicine Clerkship, 1981-85

Health Affairs:

Health Affairs Strategic Advisory Board, 2008-present
Vice Chancellor's Advisory Board, 2007-present
Chief of Medicine, 2001-08
Board of Directors, University Physicians and Surgeons, 2005-08
Medical Executive Committee of the Medical Staff, 2001-08
Search Committee for CEO, UC Irvine Medical Center, 2007-08
Executive Planning Committee, 2006-08
Hospital Campaign Physician Leadership Committee, 2006-08
Health Sciences Steering Committee, 2001-06
Strategic Planning Committee, 1997-99
Community Care Committee, 1997-98
Joint Quality Resource Management Committee, 1995-98
Executive Committee, Clinical Practice Group, 1994-96

Chao Family Comprehensive Cancer Center:

Cancer Center Program Leaders Committee, 1997-2006
Co-Leader, Population Sciences Research Program, 1994-2006
Innovations in Cancer Control Research Committee (Chair), 1999-2002
Translational Grants Selection Committee, 1994-97
Cancer Center Strategic Planning Committee (Co-Chair), 1997-98
Management Committee, Cancer Center Support Grant, 1992-96

VA Medical Center:

Dean's Advisory Committee, 2001-present
Clinical Executive Board, 1983-84
Associate Director, Primary Care Internal Medicine Residency Program, 1981-84
Laboratory and Radiology Utilization Review Committee, 1983-84
Medical and Dental Education Committee (Chair), 1980-84
Medical Service Resident Review Committee, 1979-84
Education Committee (Co-Chair), 1980-83
Transfusion Review Committee, 1979-81
Critical Care Committee, 1979-81
Cancer Committee, 1979-81

Community:

Pacific Islander Cancer Control Network Advisory Committees, 2000-07
- Office of Samoan Affairs Advisory Committee, Carson, California
- Native American Samoan Advisory Council, Pago Pago, American Samoa
- Sons and Daughters of Guam Advisory Board, San Diego, California
- Chamorro Advisory Council, Agatna, Guam
- Taularna Advisory Committee, San Mateo, California
- Office of Pacific Islander Affairs Advisory Board, Salt Lake City, Utah

Community/Campus Partnership for Health, 1999-2001
Southern California American Indian Health Working Group, 1998-201
Orange County Health Care Research Collaborative, 1996-2000
Community Advisory Board, National Office of Samoan Affairs, 1994-2000
Advisor, Orange County Health Care Agency, 1991
Orange County Task Force on Indigent Health Care, 1986-90

PUBLICATIONS:

Book Chapters, peer reviewed:

1. **Hubbell FA**, Weber MA, Winer RL, Rose DE, Ricci B. Metabolic Effects of Diuretics. In Weber MA, ed: *Treatment Strategies in Hypertension*. Miami: Symposium Specialists, 1981; pp 116-36.
2. Weber MA, **Hubbell FA**, Brewer DD, Materese JA. Interruption of Anti-hypertensive Treatment: A Challenge in Clinical Pharmacology. In Weber MA: *Treatment Strategies in Hypertension*. Miami: Symposium Specialists, 1981; pp 241-65.
3. Darrow V, **Hubbell FA**. The Annual Exam. In Zuspan FP and Quilligan EJ: *Handbook of Obstetrics, Gynecology, and Primary Care*. St Louis:Mosby, 1998; pp 506-19.
4. Chavez LR, **Hubbell FA**, Mishra SI. Ethnography and Breast Cancer Control. In Hahn RA: *Anthropology in Public and Health*. New York: Oxford University Press, 1999; pp 117-41.
5. **Hubbell FA**, Williams L. Study on Urban American Indian Communities. In: *Insuring California's Healthy Future: Use of Medi-Cal and Healthy Families Public Health Insurance Programs by California's Ethnic Minority Communities*. The Tomas Rivera Policy Institute. Pomona, CA 2002; pp 51-64.
6. Mishra SI, Luce PH, Bernstein L, **Hubbell FA**. Cancer in American Samoan Women. In Glanz, K: *Cancer in Women of Color Monograph.* Department of Health and Human Services, National Cancer Institute. Bethesda, MD, 2003; pp 1-13.

Journal Articles, peer reviewed:

1. Garbus SB, Weber MA, Priest RT, Brewer DD, **Hubbell FA**. The abrupt discontinuation of antihypertensive treatment. *Journal of Clinical Pharmacology* 1979;19:207-17.
2. **Hubbell FA**, Weber MA. Adverse effects of sudden termination of treatment of hypertension. *Postgraduate Medicine* 1980; 68:129-40.
3. **Hubbell FA**, Weber MA, Megaffin BB, Brewer DD. Acute renal impairment produced by a uricosuric diuretic. *Western Journal of Medicine* 1980;133:444-6.
4. Powers DM, Vaziri ND, Muhalwas K, **Hubbell FA**, Weber MA, Mirahmadi MK. Ticrynafen-induced acute renal failure. *Clinical Toxicology* 1981;18:425-30.
5. **Hubbell FA**, Weber MA, Winer RL, Rose DE. Biochemical cardiac risk factors during diuretic therapy. *Archives Internationales de Pharmacodynamie et de Therapie* 1982; 256:123-33.
6. **Hubbell FA**, Weber MA, Drayer JIM, Rose DE. Combined central and peripheral sympathetic blockade: absence of additive antihypertensive effect. *American Journal of the Medical Sciences* 1983;285:18-26.
7. Weber MA, Drayer JIM, **Hubbell FA**. Effects on the renin-angiotensin system of agents acting at central and peripheral adrenergic receptors. *Chest* 1983;83S:374-7.
8. **Hubbell FA**, Weber MA, Drayer JIM, Rose DE. Comparative antihypertensive and endocrinologic effects of clonidine and prazosin in patients with essential hypertension. *Southern Medical Journal* 1984;77:1264-8.
9. Uliana RL, **Hubbell FA**, Wyle FA, Gordon GH. Mood changes during internship. *Journal of Medical Education* 1984;59:118-23.
10. **Hubbell FA**, Greenfield S, Tyler JL, Chetty K, Wyle FA. The impact of routine admission chest x-ray films on patient care. *New England Journal of Medicine* 1985;312:209-13.
11. Gordon GH, **Hubbell FA**, Wyle FA, Charter RA. Stress during internship: a prospective study of mood states. *Journal of General Internal Medicine* 1986;1:228-31.

Journal Articles, peer reviewed (continued):

12. Waitzkin H, Akin BV, de la Maza L, **Hubbell FA**, Meshkinpoor H, Rucker L, Tobis JS. Deciding against corporate management of a state-supported academic medical center. *New England Journal of Medicine* 1986;315:1299-1304.
13. Rucker L, **Hubbell FA**, Frye EB, Akin BV. Screening of electrolytes, BUN, and glucose levels in medical admissions; impact on patient management. *Western Journal of Medicine* 1987;147:287-91.
14. Akin BV, **Hubbell FA**, Frye EB, Rucker L, Friis R. Efficacy of the routine admission urinalysis. *American Journal of Medicine* 1987;82:719-22.
15. **Hubbell FA**, Akin BV. The questionable value of routine admission urinalyses (epitome). *Western Journal of Medicine* 1987;147:321-22.
16. Frye EB, **Hubbell FA**, Akin BV, Rucker L. Usefulness of routine admission complete blood cell counts on a general medical service. *Journal of General Internal Medicine* 1987;2:373-6.
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